08-00723 Myron D. Buck

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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|----|-----|-----|----|-----|
| 20 | 08  | 04  | UL | )   |

|  |                | 1- For State<br>Registrar  | Certifica                | ite of                  | Death  |                                 | Re  | g. No.  |  |   |  |
|--|----------------|--|--------------------------|-------------------------|--|---------------------------------|---|---|--|---|--|
| Physici<br>dical Exam  |                | Decedent's Name (First, Middle, Last)     MYRON DANIEL BUCK                                      |                          |                         |  |                                 | 2. Date of Death<br>Month                       | Day Yea   |  | of Death<br>3 hrs                               |  |
| uicai Exam   | iiiei          | 4a. Facility Name (if not institution, give street and number)                                   | -                        | 41                      | b. City, Town, or Lo                         | ocation of Deat                 | January 26                                      | 4c. County                                      | of Death                               |   |  |
|  |                | Peninsula Regional Medical Center  |                          |                         | Salisbury                                    | Liell Later                     | lo p(Pin)                                       | Wicomico th(MM/DD/YYYY) 9. Birthplace (State or |  |   |  |
| Funeral<br>Director  |                | 5. Social Security Number 6. Sex 7. Age 1 X M 2 F  | (In yrs. last birth      | Yrs.                    | If Under 1 Year  Months Days                 | If Under 24Hi<br>Hours Mi       |   | `   | Foreign PEN Country)                   | NSYLVA:   |  |
| w any  |                | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Town o        | or Locatio              | on   |                                 |   |   |  | ide City Limits                                 |  |
| Aaryland<br>28a-f show<br>1 at once.   | 호              | MARYLAND WICOMICO  | FRUITI                   | LAND                    |  |                                 |   |   |  | Yes 2 No  |  |
| the Mary<br>a or 28a-<br>tified at   | Director       | 10e. Street and Number  111 CLYDE AVENUE   |                          |                         | 10f. Zip Code 21826                          |                                 | 10  | g. Citizen of WI                                | nat Country?                           |   |  |
| AID 21215-0036 2 should be filted within 72 hours after death with the Maryland h and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once   | Funeral        | 11. Marital Status 1 Never Married 2 Married 12. Was Decedent E Armed Forces? 1 Yes 2            |                          |                         | Decedent of Hispa<br>es, specify Cuban, I    |                                 |   |   | e - American India<br>e, etc.          | an, Black,                                      |  |
| after d<br>al", or<br>ner m  | by Fi          | 3 Widowed 4 X Divorced of Parker of Dates  | X No                     | 1                       | Yes 2 X No                                   | specify:                        |   | Specify:  | WHITE                                  |   |  |
| nours  |                | 15. Decedent's Education (Specify only highest grade comp  | ه است                    |                         | 's Usual Occupatio                           |                                 |   | 16b. Kind of Bu                                 | usiness/Industry                       | <u>. –                                     </u> |  |
| n 72 l<br>n 72 l<br>lical F  | Completed      | Elementary/Secondary (0-12) College (1-4 or 5-   | +)                       | BUILI                   | · ·  |                                 | ,   | CONSTR  | HOTTON                                 |   |  |
| 5-0056 led within 7 Hygiene. other than  | E              | 17. Father's Name (First, Middle, Last)  |                          | DOIL                    |  | 3.Mother's Nan                  | ne (First, Middle, N                            |   |  |   |  |
| LLLIS-0030<br>uld be filed within 72<br>Mental Hygiene.<br>marked other than<br>c event, the <u>Medical</u>  | Be C           | EDWARD E. BUCK   |                          |                         |  |                                 | ELLE MEZ  |   |  |   |  |
| and 2 should be filed within 72 leath and Mental Hygiene. Item 27 is marked other than transmatic event, the Medical   | 10 E           | 19a. Informant's Name/Relationship (Type, Print )  | 19b                      | . Mailing               | Address (Street                              |                                 |   |   | vn, State, Zip Coo                     | de)   |  |
| d 2 sho<br>Ith and<br>n 27 is  |                | EDWARD E. BUCK/ FATHER   |                          |                         | LYDE AVEN                                    |                                 |   |   |  |   |  |
| permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tinjury or other traumatic event, the Meg   |                | 20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State                          | 20b. Place of the MELSOI | f Disposit<br>ry or oth | tion (Name of ceme<br>er place)<br>CREMATORY | etery,                          | Date  |   | - City or Town, Si                     |   |  |
| permit. Pages 1 Department of F Important: If i  |                | 4 Donation 6 Other Specify:  | HENLO                    |                         |  |                                 | 28-08   |   | ORD, DEL                               |   |  |
| permit<br>Depart<br>Impor<br>injury  |                | 21. Signature of Power at State of Control   |                          | WE                      | TSON Address ST AVENUE                       | RAL SE                          | RVICES: L                                       | TD<br>DELAWAR                                   | E. 19970                               | )   |  |
| hysician   |                | 23a. Part I. Enter the disease, or complications that caused t                                   | he death. Do not         |                         |  |                                 |   |   | eart Appro                             | ximate Inter                                    |  |
| /Medical   |                | failure. List only one cause on each line.  Immediate Cause (Final disease a Multiple Injuries   |                          |                         |  |                                 |   |   | Betwee                                 | een Onset a<br>Death                            |  |
| taminer  |                | or condition resulting in death)  Due to (or as a consec   | quence of):              |                         |  |                                 |   |   |  |   |  |
|  | L              | Sequentially list conditions, b  | augano of):              |                         |  |                                 |   |   | _                                      |   |  |
|  | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated     | querice or).             |                         | W-12-  |                                 |   |   | 0.00                                   |   |  |
| od<br>sit  | Xar            | events resulting in death) Last  Due to (or as a consect   | quence of):              |                         |  |                                 |   |   |  |   |  |
| xecuted<br>n and<br>- transit  |                | d.   |                          |                         |  |                                 | _   | <del></del> .                                   |  |   |  |
| rous,<br>icate be executed<br>physician and<br>the burial - transi   | Medical        | UNPENDED AMENDED   |                          |                         |  |                                 |   | Dad Date o                                      | f doliver                              |   |  |
| The law requires that the death certificat cate has been signed by the attending phyage 2 should be detached for use as the  | sician/M       | IF FEMALE: 23c. If yes, outcom   1 Live birth   past 12 months?   4 Pregnant at t                | 2                        |                         | al death 3 er (Specify)                      | Ectopic preg                    | nancy   | 23d. Date o<br>Month                            | Day                                    | Year  |  |
| e death<br>the att   | Physi          | 1 Yes 2 No 9 Unknown 9 Unknown   |                          |                         |  |                                 |   |   |  |   |  |
| that the cred by the detached  | by P           | Part II. Other significant conditions contributing to death                                      | but not resulting        | in the u                | nderlying cause giv                          | ven in Part I.                  |   |   | ribute to the caus                     |   |  |
| uires that<br>n signed t   |                |  |                          |                         |  |                                 |   |   | Probably 4                             | 1 3 11/2 200                                    |  |
| The law requir<br>ficate has been s<br>, page 2 should t   | Completed      |  |                          |                         |  |                                 | 24a. Was autop                                  | sy  | Were autopsy fin<br>prior to completic |   |  |
| The la   | E O            |  |                          |                         |  |                                 | perfor<br>1 <b>V</b> Yes                        |   | death?<br>1 ✔ Yes                      | 2 No  |  |
| clan: The<br>certificate<br>ector, page  | Be C           | 25. Was case referred to medical examiner?   |                          |                         |  | of Death (Chec                  | k only one)                                     |   |  |   |  |
| hysiclan<br>this certi   | 70 E           | 1 Ves 2 No   | nt 2 🗸 ER/Ou             |                         | 0  |                                 |   | Residence 6                                     | Other:                                 |   |  |
| ending Pl<br>ath.<br>or: After<br>the funera   |                | 27. Manner of Death  1 Natural 5 Pending  28a. Date of Injur (Month. Day)  August 2008           | y 28b. T<br>ar) 1129     | Time of Ir<br>hrs       |  | at Work?                        | Driver auto                                     | now injury occur<br>fixed object                |  |   |  |
| Invision of vital in the properties of the properties of the control of the properties of the properti | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Loc.                      |                          | rm, stree               | t, factory, office bu                        | ilding, etc.                    | 28f. Location (S<br>or Town, S<br>Old Furness F |   | ber or Rural Rout                      | te Number, C                                    |  |
| To the Hospital or Attend<br>within 24 hours after death<br>To the Funeral Director:<br>completely filled in by the  |                | 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of exam                         | knowledge, dea           | ith occurr              | red at the time, date                        | e and place, and death occurred | nd due to the caus                              | e(s) and manne                                  | er as stated.                          | (s)   |  |
| To the within 7  | Medical        | and manner stated.  29b. Signature and title of certifier  |                          |                         | 29c. License                                 |                                 |   |   | ned (Month, Day                        |   |  |
|  | -              | Janha Helf Mr.   | )                        |                         | V.D.0  |                                 |   | January 2                                       |  | ,   |  |
| 6  |                | 30. Name and address of person who completed cause of de<br>Tasha Greenberg MD. Assistant Medica |                          | 1111                    | Penn Street, B                               | Baltimore, N                    | /ID 21201                                       |   |  |   |  |
|  | tate           | 31. Date filed (Month, Day, Year) 32. Resistrar  |                          | -                       |  |                                 |   |   |  |   |  |
| Regis  | trar           | JAN: 3 0 2008 Read   | us St.                   | AN                      | 3443   |                                 |   |   |  |   |  |
| 17 Rev 1/2   |                | SHI. 0 0 2000  | OR                       | IGINAL                  |  |                                 |   |   |  |   |  |

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Janet Lee Potter Bennett :30 AM landary 28 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town. or Location of Death Examiner Camp ford orien ar If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 15, 1 6. Sex 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 🖾 F 213-42-2665 64 1944 Director Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.
Is marked other than "natural" or home 220 and 100 and 10 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 X Yes 2 No Director Perryville Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21903 Perryvilla Apt. No. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation traumatic event, the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Twelve Years Homemaker Personal Residence permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 Is marked othe any Injury or other traumatic event, office. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie G. Williams Elmer Matthew Potter 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqualin G. Ashford (sister) P.O. Box 217, Perryville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Mark's Cemetery 01/31/08 Perryville, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21903-0766 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** kehnilasidav NU disease or condition resulting in death) /Medical Examiner Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the attending physician certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pr pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death 2 Fetal death 3 Ectopic pregnancy in the past 12 mont Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Division or Vital Record Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2∐No After this certificate or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yeş 2 10 Certification: To 2 ER/Outpatient 3 DOA 1 | Inpatient 27. Man r of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day Year) 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Dale signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Registrar's Signature State Year) 3 0 Registrar

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amend item 1 per doc 9876 2-15-08 vt.
State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Georgia Merlin Noakes Cayton **Physician** Month Day Year 9:30 a M Noakes Cayton January 25, 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Bedford Court Assisted Living Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕱 F Yrs Director 529-09-4059 88 July 7, 1919 Nebraska Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene, Important: If them 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be noritinal anone. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Directo Maryland Carroll Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9004 Brown Church Road 21771 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify. **p** 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Special Education/ Elementary/Secondary (0-12) College (1-4or 5+) Teacher's Aide Montgomery County Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Calvin Noakes Myrtle Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph B. Cayton/Son 9004 Brown Church Road, Mount Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 28, Jan. 4 Donation 5 Dother (Specify) Fort Lincoln Cemetery 2008 Brentwood, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. . Kein Stile 500 University Blvd, W., Silver Spring, MD 20901 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 Weeks Pneumonia /Medical Due to (or as a consequence of): Examiner Emphysema Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Unknown Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' certificate 1□ Yes 24 No 1 Yes 2 No To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Mother (Specify) ပ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Assisted After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Living 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident hin 24 hours after death the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 释答certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

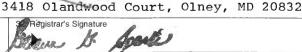
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State Registrar

Joseph Reilly, MD 31. Date filed (Month, Day, Year) JAN 2 8

and 30. Name an deless of person who completed caus

29b. Signature and title of certifier



death (Item ype, Print)

DHMH 17 Rev 1/2001

29c. License number

D39190

29d. Date signed (Month, Day, Year)

January 25, 2008

|                   |  |                | T- State C State Registrar  | of Maryland                                |                  | rtment of F<br>tificate of             |                                | Mental Hy                             | giene<br>Reg. No.        |                             |  |
|-------------------|--|----------------|---|--|------------------|--|--------------------------------|---------------------------------------|--------------------------|-----------------------------|--|
| - 7               |  |                | Decedent's Name (First, Middle, Last)   |  |                  |  |                                | 2. Date of De                         | ath                      | 2000                        | 3. Time of Death                           |
|                   | Physici<br>/Medic  |                | Mary Teresa Cain  |  |                  |  |                                | January                               | <sup>Day</sup> 26,       | 2008                        | 7:18p M                                    |
|                   | Examir   |                | 4a. Facility Name (If not institution, give street and nu   | mber)                                      |                  | 4b. City, Town, o                      | r Location of Dea              | th                                    | 4c. (                    | County of Death             |  |
|                   |  |                | Holy Cross Hospital   |  |                  |  | r Spring                       |                                       |                          | Montgo                      |  |
|                   | Funeral<br>Director  |                | 5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F  | 7. Age (In yrs. la                         | Ven              | If Under 1 Year<br>Months Days         | If Under 24 Hrs<br>Hours Min   |                                       | y, Year)                 | Coun                        | lace (State or Foreign<br>try)<br>sylvania |
|                   | pu »   |                | Usual Residence of Decedent  10a. State 10b. County   | 10c City                                   | r, Town or Loc   | ration                                 |                                |                                       |                          | 1                           | 0d. Inside City Limits                     |
|                   | shoved   | 5              |   | ,  |                  |  |                                |                                       |                          | '                           | 1 ☐ Yes 2 No                               |
|                   | the N<br>28a-f<br>rotific  | Director       | Maryland   Montgome   10e. Street and Number  | ery  | Silve            | r Spring                               |                                |                                       | 10a Citiz                | en of What Coun             | trv?                                       |
|                   | with<br>sa or<br>t be r  |                | 8201 16th Street, #109  | <b>a</b>                                   |                  | 2091                                   | 0                              |                                       | - g                      | USA                         | -,-  |
|                   | ns 2%  | era            | 11 Marital Status 12. Was Dec   | edent Ever in U.S                          | S. 13. V         | 1                                      |                                | Specify Yes or No<br>rto Rican, etc.) | _ 1                      | 4. Race - Americ            |  |
| 36                | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral     | Armed Fr  1 Never Married 2 Married 1 Yes If Yes, 3 Widowed 4 Divorced Year or D  | 2 ⅓ No<br>ive                              |                  | Yes, specify Cub  ☐ Yes 2  ☑ No        |                                | rto Rican, etc.)                      |                          | Black, White, Specify: V    | <sup>etc.</sup><br>√hite                   |
| 21215-0036        | 2 hou  | ted            | 15. Decedent's Education  |  |                  | ent's Usual Occup                      |                                |                                       | 16b. Kir                 | nd of Business/Inc          | dustry                                     |
| 215               | thin 7<br>e.<br>an "n<br>Medi  | Completed      | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (   |  | life. E          | kind of work done<br>OO NOT use retire | d) auring most of wo           | orking                                |                          |                             |  |
| 7                 | er th  | 8              | 12  | ·  | Homem            | aker                                   | 1                              |                                       |                          | Home                        |  |
| Maryland          | be file<br>tal H<br>d oth  | Be             | 17. Father's Name (First, Middle, Last)   |  |                  |  |                                | me (First, Middle,                    |                          | Surname)                    |  |
| <u>Y</u> a        | ould<br>Men<br>harke   | မ              | Robert J. Townsend  |  | T                |  |                                | B. Hess                               |                          |                             |  |
| Jar               | 2 sh<br>n and<br>is m  |                | 19a. Informant's Name/Relationship (Type. Print)  Leonard F. Cain/Husband   | ٦  | 1                | •                                      |                                | Rural Route Numb                      |                          |                             | Code)<br>MD 20910                          |
| e)                | t and<br>Health<br>Sm 27<br>ther t   |                | 20a. Method of Disposition  |  | <u> </u>         | sition (Name of                        | bereet,                        | Data                                  |                          | cation - City or To         |  |
| altimore,         | ages<br>nt of h  |                | 1 Burial 2 ☐ Cremation 3 ☐ Removal from   | State                                      | emetery, cren    | natory or other pla                    | i i                            | in. 30,                               |                          | ,                           |  |
| ≝                 | it. Pe   | 72             | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee   | Gat  |                  | eaven Ce<br>. Name and Addre           |                                | 2008                                  | Silv                     | er Sprin                    | ng, Maryland                               |
| Ba                | perm<br>Depa<br>Impo<br>any i  |                | 21. Signature of Purieral Service Licensee  |  | r'r              | ancis J.                               | Collins                        | Funeral                               |                          |                             |  |
|                   | -  |                | 23a. Part1. Enter the disease, or complications that  | caused the death                           | n. Do not ente   | O Univer<br>or the mode of dyi         | sity Blv<br>ng, such as cardia | d W was ac or respiratory a           | Silv<br>rrest,           | er Sprin                    | pproximate                                 |
|                   | Dhysisian  | Q 19           | shock, or heart failure. List only one cause on Immediate Cause (Final  |  | dial T           | nfarctio                               | n                              |                                       |                          |                             | Interval Between<br>Onset and Death        |
|                   | Physician /<br>/Medical  |                | resulting in death)   | (or as a consequ                           |                  | nrarcero                               | 11                             |                                       |                          |                             |  |
| 123               | Examiner   |                |   | ic Shock                                   |                  |  |                                |                                       |                          |                             |  |
| 345               |  | Jer            | Sequentially list conditions, it any, leading to immediate cause. Enter Underlying  | (or as a dotted)                           | lence of):       |  |                                |                                       |                          |                             |  |
|                   | outed<br>id<br>ansit   | Examiner       | that initiated events  Acute  | e Renal                                    | Failur           | е                                      |                                |                                       |                          |                             |  |
| Ó                 | exe<br>an ar<br>rial-tı  | EX             | resulting in death) Last Due to   | (or as a consequ                           | uence of):       |  |                                |                                       |                          |                             |  |
| 68760,            | icate be executed<br>physician and<br>s the burial-transit   | dical          | d. Atria  | al Fibri                                   | llatio           | n                                      |                                |                                       |                          |                             |  |
|                   | ing p  |                | IF FEMALE:  |  |                  |  |                                |                                       |                          |                             | -  |
| P.O. Box          | ath co   | ian/           | 23b. Was decedent pregnant 1 Live   | itcome pf pregna<br>birth 2□Fetal          | Ideath 3□        | Ectopic pregnanc                       | у                              |                                       | 2                        | 3d. Date of delive<br>Month | ery<br>Day Year                            |
| <u>.</u>          | ne de<br>the a   | Physician/M    | 1 ☐ Yes 2 ☐ No 4 ☐ Preg<br>9 ☐ Unknown 9 ☐ Unkr   | nant at time of de<br>nown                 | eath 5∟          | Other (specify) _                      |                                |                                       |                          |                             | ,  |
| σ.                | The law requires that the death certif<br>ite has been signed by the attending<br>page 2 should be detached for use as   | P              | Part II. Other significant conditions contributing to c   | death but not rest                         | ulting in the un | iderlying cause giv                    | ven in Part I.                 | 23e. Did t                            | obacco u                 | se contribute to th         | ne cause of death?                         |
| Records,          | sign<br>d be   | d by           |   |  | -                |  |                                | 10                                    | Yes 2[                   | ]No 3∏Prob                  | ably 4 ⊠Unknown                            |
| 202               | w requir<br>been si<br>should I  | Completed      |   |  |                  |  |                                | 24a. Was                              | an                       | 24h Wore auto               | psy findings available                     |
| Ř                 | he lav<br>e has  | mp             |   |  |                  |  |                                | auto                                  |                          | prior to con<br>death?      | mpletion of cause of                       |
|                   |  |                | 25. Was case referred to medical  |  |                  |  | 26 Place of D                  | 1  Yes<br>eath (Check only o          |                          | 1 ☐ Yes                     | 2 No                                       |
| 5                 | Physiclan:<br>r this certifica<br>ral director, p  | o Be           | examiner?   | Inpatient 2 □                              | FR/Outpatien     | t 3 DOA Oth                            | or:                            | Home 5 ☐ Resi                         |                          | COthor (Specif              |  |
| Ö                 | ding Phy<br>After this<br>funeral o  |                | 27. Manner of Death 28a. Date   | of Injury                                  | 28b. Time of     |  |                                | 28d. Describe                         |                          |                             | 77   |
| ion               |  | ațioi          | 1 ☑ Natural 5 ☐ Pending (MOI) 2 ☐ Accident investigation  | nth, Day Year)                             | Injury           |  | Yes 2 □ No                     |                                       |                          |                             |  |
| Division or Vital | al or Attendate after death  | Certification: |   | e of injury - At ho<br>ding, etc. (Specify |                  | eet, factory, office                   |                                | 28f. Location (City or To             | Street and<br>wn, State) | d Number or Rura<br>)       | d Route Number,                            |
|                   | To the Hospital or Within 24 hours after To the Funeral Director Completely filled in b  | edical C       | 29a. Certifier (Check only one)  29a. Certifying Physician: To the deficiency of the learning |  |                  |  |                                |                                       |                          |                             |  |
|                   | To the Hos<br>within 24 h<br>To the Fun<br>completely  | Me             | 29b. Signature and title of certifier   | 7  |                  | 29c. Licens                            | se number                      |                                       | 29d. Date                | e signed (Month,            | Day, Year)                                 |
|                   | 17   |                | > 111 m Lange   | 2  | ι                |  | D625                           | 20                                    | Jan                      | uary 27,                    | 2008                                       |
| 7                 | U  |                | 30. Name and address of person who completed cau  | se of death (Item                          | 23a) (Type,      | Print)                                 |                                |                                       |                          |                             |  |
|                   |  |                | Maria D'Arbella, MD   |  |                  |  | , Silver                       | Spring,                               | MD                       | 20910                       |  |
| ľ                 | Sta  |                | 31. Date filed (Month, Day, Year) 32  | egistrar's Signa                           | iture            | nade p                                 |                                |                                       |                          |                             |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** 02:00 AM Ruth Anna Cliff 28, January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Manor Healthcare Center Rising Sun Ceci1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ■ M 2 X F Director 219-28-7420 101 May 26, 1906 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Ceci1 1 ∐ Yes 2 🔯 No Director Rising Sun 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1881 Telegraph Road 21911 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □ Yes 2√2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Warren Meekins 2 Sadie Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is any Injury or other trau once. May C. Davig / Daughter 4730 Enchanted Valley, Middleton, Wisconsin 53562 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State February 4 □ Donation 5 □ Other (Specify) North East Methodist 1, 2008 North East, Maryland 21. Signature of Emeral Service Licens 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ue to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) signed by the a 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has autopsy this certificate 1∐ Yes 2 40 or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27 Manner 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral 5 ☐ Pending investigation 1 Watural 1 🗌 Yes 2 🗆 No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001 e and address of person who com

Silv

23 31. Date filed (Month, Day, cause of death (Item 23a) (Type, Print)

327Registrar's Signature

22230

OH M1) 219

|  | 1. Decedent's Name (First, Middle   | #5 Per FH g87   | - 1, -1, 0                           |   |   | 2. Date of Deat                         | e <b>g. No</b> .            |                        | 3. Time of Death                                   |
|--|---|---|--------------------------------------|---|---|---|-----------------------------|------------------------|--|
| Physician  |   | athryn  | Cronkrig                             | rh t  |   | Month<br>January                        | Day                         | Year 2008              | 1:40a  |
| /Medical<br>Examiner   | 4a. Facility Name (If not institution   |   | OT OTHER TE                          | <u> </u>  | or Location of Death                    |   |                             | nty of Death           |  |
| Zammo  | St. Mary's Ho   | spital  |                                      | Leona   | rdtown                                  |   | S                           | t. Man                 | ry's   |
| Funeral  | 5. Social Security Number   | 1 M 2 N E   | In yrs. last birthday)               | If Under 1 Year<br>Months Days                              | If Under 24 Hrs.<br>Hours Min.          | 8. Date of Birth (Month, Day,           | Year)                       | 9. Birth               | place (State or Forei                              |
| Director   | <b>375</b> -40-0071   | 6   | 8 Yrs.                               |   |   | 03/25/1                                 | .939                        |                        | nigan  |
| w +  | Usual Residence of Decedent  10a. State 10b. County   | 1   | 0c. City, Town or Lo                 | cation  |   |   |                             |                        | 10d. Inside City Limi                              |
| Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Items 23a or 28a-f show my njury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director | Maryland St   | . Mary's  | Charle                               | tte Hall  |   |   |                             |                        | 1 ∐Yes 2 📉 N                                       |
| notifi<br>rec  | 10e. Street and Number  | · Hary S  | CHart                                | 10f. Zip Code   |   | 1                                       | 0g. Citizen                 | of What Cou            | intry?   |
| st be  | 38125 Cheyenn   | e Court   |                                      | 206   | 22                                      |   | U                           | SA                     |  |
| yerier:  ty the Medical Examiner must be notified  ty the Medical Examiner must be notified  Completed by Funeral Director   | 11. Marital Status  | 12. Was Decedent Everaged Armed Forces?                             | er in U.S. 13.                       | Was Decedent of I   | Hispanic Origin? (Span, Mexican, Puert  | pecify Yes or No-                       |                             | Race - Ameri           |  |
| or fr  | 1 □ Never Married 2 □ Marri   | ed 1 ☐ Yes 2 📉 No<br>If Yes, Give                                   |                                      | 1 ☐ Yes 2√2 No  |   | o moun, oto.,                           | ļ                           | ecify:                 | , 610.   |
| tural<br>al Exa  | 3 Widowed 4 Divorced  | Year or Dates:  | 10a Daga                             | donalo i lovol Occor  |   |   |                             | V                      | √hite  |
| "nat<br>edica  | 15. Decedent<br>(Specify only highes  | t grade completed)  | (Give                                | dent's Usual Occu<br>kind of work done<br>DO NOT use retire | pation<br>during most of wor<br>ed)     | king                                    | 16b. Kind o                 | f Business/Ir          | ndustry  |
| the M  | Elementary/Secondary (0-12)   | College (1-4or 5+)  |                                      | get Anal  |   |   | Dent                        | of th                  | ne Navy  |
| d other<br>event, f<br>Be C  | 17. Father's Name (First, Middle,   | Last)   |                                      | .goc mar  |   | ne (First, Middle, I                    |                             |                        | ie navy  |
| atic ev<br>To B  | Joseph  | Archambault   |                                      |   | Marjori                                 | le Ev                                   | a                           | Cut1e                  | er   |
| s ma   | 19a. Informant's Name/Relations   | nip (Type. Print)   | 19b. Maili                           | ng Address (Street  | and Number or Ru                        | ıral Route Number                       | ; City or To                | wn, State, Zij         | p Code)  |
| n 27 I   | Mary A. Glotfe  | lty/Daughter  | 3812                                 | 5 Cheyen  | ne Ct., C                               | Harlotte                                | Hall                        | . MD 2                 | 20622  |
| or oth   | 20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation   | 3 ☐Bernoval from State  | 20b. Place of Dispo<br>cemetery, cre | sition (Name of<br>matory or other pla                      | ice)                                    |   |                             | on - City or T         |  |
| Juny   | 4 □ Donation 5 □ Other (S   | pecify)   | Brinsfiel                            | ld-Echols   | Cr. 1/3                                 | 0/2008                                  | Char1                       | otte I                 | Hall, MD   |
| any in   | 21. Signature of Funeral Service  |   | )817   <sup>22</sup>                 | 2. Name and Addr<br>Brinsfiel                               | ess of Facility                         | Funeral                                 | Home.                       | P.A.                   |  |
| = 60 ()  | Mulan Co  | apes Or   |                                      |   |   |   |                             | e Hal                  | 1, MD 206  |
|  | 23a Fart1. Enter the disease, or shock, or heart failure. List  | 4 4 1 4   |                                      |   | ing, such as cardiac                    | or respiratory arre                     | est,                        |                        | Approximate<br>Interval Between<br>Onset and Death |
| ician<br>dical   | Immediate Cause (Final disease or condition resulting in death)   |   | ENSION                               |   |   |   |                             |                        |  |
| niner  |   |   | consequence of):                     | SHOCK   |   |   |                             |                        |  |
|  | Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | D   | consequence of;                      |   |   |   |                             | -                      |  |
| rial-transit   | Cause (Disease or injury that initiated events  | CONGES  | TIVE 1                               | TEART   | PAILUR                                  | LE                                      |                             |                        |  |
| rial-t   | resulting in death) Last  | Due to (or as a o   | consequence of):                     |   |   |   |                             |                        |  |
| the burial-transit   |   | d   |                                      |   |   |   |                             |                        |  |
| e as   | IF FEMALE:  |   |                                      |   |   |   |                             |                        | -  |
| d by the attending pletached for use as Physician/Mee  | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome pf   | Fetal death 3                        | Ectopic pregnanc  | у                                       |   |                             | Date of deliv<br>Month | rery<br>Day Year                                   |
| detached to Physic   | 1 ☐ Yes 2 ☒No<br>9 ☐ Unknown  | 4□ Pregnant at tir<br>9□ Unknown                                    | ne or death 5L                       | Other (specify) _   |   |   |                             |                        |  |
| D 0 1 -  | Part II. Other significant condition  | ns contributing to death but  | not resulting in the u               | nderlying cause gi  | ven in Part I.                          | 23e. Did tol                            | pacco use c                 | ontribute to t         | the cause of death?                                |
| signed lid be det  | PERFORATED  | DIVERTICE   | ILAR ABS                             | CESS OF   | = colon                                 | 1 □ Ye                                  | es 22 No                    | 3 ☐ Pro                | bably 4 dunkno                                     |
| certificate has been signe rector, page 2 should be d  | METABOLIC   | ACI DOSIS   | RENAL                                | FAILUR  | E                                       | 24a. Was a                              | n 24                        | Ih Ware auto           | oney findings availa                               |
| age 2  | 7-1710-010  |   | -                                    |   |   | autops                                  | med?                        | death?                 | opsy findings availa<br>ompletion of cause o       |
| or, pa   | 25. Was case referred to medical  |   |                                      |   | 26 Place of Dog                         | 1 Yes :                                 |                             | 1 □ Yes                | 2K No  |
| To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Comi  | examiner?<br>1 ☐ Yes 2 No   | Hospital:   | 2 ☐ ER/Outpatier                     | nt 3□ DOA Ott   |   | ome 5 ☐ Reside                          |                             | Other (Speci           | (fx)   |
| n: T   | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day )                                | 28b. Time o                          |   |   | 28d. Describe ho                        |                             |                        |  |
| ral Director: After to the funeral led in by the funeral Certification:  | 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investig   | ation   | ear/ mjury                           |   | Yes 2 □ No                              |   |                             |                        |  |
| by t   | 3 ☐ Suicide 6 ☐ Could r<br>4 ☐ Homicide determ  |   | - At home, farm, str<br>(Specify)    | eet, factory, office  |   | 28f. Location (St<br>City or Town       | reet and Nu                 | mber or Rur            | ral Route Number,                                  |
| Sed in Sed in Sed  |   |   |                                      |   |   |   |                             |                        |  |
| o the Fune<br>ompletely fil<br>Medical   | (Check only 2) Medical  | <b>g Physician:</b> To the best of e<br>Examiner: On the basis of e | xamination and/or in                 | h occurred at the to<br>vestigation, in my                  | ime, date and place opinion, death occu | e, and due to the curred at the time, d | ause(s) and<br>ate and plac | manner as              | stated.<br>to the cause(s)                         |
| mple Med   | one)  29b. Signature and title of certifier   | and manner state  | d                                    | 29c. Licens   |   |   |                             |                        |  |
| 8  | 255. Organizate and title of Certifie   | 20  | M.D                                  |   | 00517                                   |   | au. Date sig                | ned (Month,            | 2008   |
|  | 20 Nome end adding .  | who completed as  |                                      |   |   |   | - ' /                       | 071                    | 7000   |
| 2 1 2  | 30. Name and address of person  | who completed cause of deal   | in (item 23a) (Type,                 | rnnt)   | WOOD Y                                  | MD 20                                   | 171                         |                        |  |
| bin I  | KAE T. A  | UNG POB   | V X 2/                               | HULLYI  | VVOOD                                   | 111 201                                 | ロット                         |                        |  |

State of Maryland / Department of Health and Mental Hygiene-1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dorothy Margaret Clayton January 23, 2008 0850 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Carroll Westminster If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 KF Director Yrs 74 213-32-2730 Jul 6, 1933 New Jersey Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 412 Poole Road B4 21157 or Items 23a USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Health and Mental Hygiene. Health Is marked other than "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles J. Schwarz Margaret Ranken 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health as Important: If item 27 Is any Injury or other trau once. John D. Clayton, husband 412 Poole Road B4, Westminster, MD 21157 20b. Place of Disposition (Name of Scoreley), crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Crematory 1/25/2008 Winfield, MD \* 4 ☐ Donation \* 5 ☐ Other (Specify) 21. Signatur / Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 anu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HETERIOSCULLOTIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal dea 4 Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 Other (specify) P.O. 1 9☐ Unknown 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 0 STROKE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 2 No 1 Yes the Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 01 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Mann f Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of After 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by hours after 4 | Homicide within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manifestated. (Check only one) 29b. Signature and the of certifier 20806 2008 ullesus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 180RTY RD ELDERSBURG MD 21784 LURNER Sure 102 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar **JAN 28** 2008

|   |  |                | For  |   | State o   | f Mar                  | ryland /                     |   |   |                         |                     | and Me       | ental Hy                         | giene            |   |          |  |
|---|--|----------------|--|---|---|------------------------|------------------------------|---|---|-------------------------|---------------------|--------------|----------------------------------|------------------|---|----------|--|
| _   |  | _              | - State<br>Registrar   |   |   |                        |                              | Cer                                     | tificate  | e of L                  | Death               |              |                                  | Reg. No.         | 200                                       | Ω        | 01.000   |
| -   | Physicia<br>/Medic   |                | 1. Decedent's Nam<br>Maurine   | ne (First, Middle, L                      | S.  |                        |                              |   |   | Du1                     | in                  |              | 2. Date of De<br>Month<br>Januar | Day              | , 2008                                    |          | 3. Time of Death 12:30 A M                         |
|   | Examin   | and the        | 4a. Facility Name (  | If not institution, g                     | ive street and nu   | mber)                  |                              |   | 4b. City,   | Town, or                | Location            | of Death     |                                  | 4c.              | County of De                              | ath      |  |
|   |  |                | Suburba  |   | Hospi   |                        |                              | 1:41 1 1                                | Beth<br>If Under  |                         | If Under            | 24 Hrs. 1    | Dotte of Bio                     |                  | ontgom                                    |          | (0)  |
|   | Funeral  |                | 5. Social Security N<br>579–18–6   |   | Sex<br>1 ☐ M 2 🖾 F  | 7. Age                 | (In yrs. last<br>88          | Yrs.                                    | Months  | Days                    | Hours               |              | B. Date of Bir<br>(Month, Da     |                  | 1   | Countr   | ce (State or Foreign<br>y)                         |
| (ac.)                                     | Director   |                | Usual Residence o  | of Decedent                               |   |                        |                              |   |   |                         |                     |              | 02/16/                           | 1919             | Io  | wa       |  |
|   | /land<br>low<br>at   |                | 10a. State   | 10b. County                               |   |                        | 10c. City, To                | own or Loc                              | cation  |                         |                     |              |                                  |                  |   | 10       | d. Inside City Limits                              |
|   | Mar<br>a-f sh<br>ified   | 햐              | MD   | Montgome                                  | ery   |                        | Bethe                        | sda                                     |   |                         |                     |              |                                  |                  |   |          | 1KIYes 2 No  |
|   | th the<br>or 284<br>e not  | Director       | 10e. Street and Nu   | ımber                                     |   |                        |                              |   | 10f. Zip  | Code                    |                     |              |                                  | 10g. Citi        | izen of What                              | Countr   | y?   |
|   | 23a ust b  | ral            | 9707 01d   | Georget                                   |   |                        | _                            |   | 208   |                         |                     |              |                                  |                  | ed Sta                                    |          |  |
| 336                                       | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Fur         | <ul><li>11. Marital Status</li><li>1 □ Never Mar</li><li>3 ☒ Widowed</li></ul>           | ried 2 Married 4 Divorced                 | 12. Was Dec<br>Armed Fo<br>1 Tes<br>If Yes, Gi<br>Year or D | orces?<br>2 🔼 No<br>ve |                              | 1                                       | . Was Decedent of Hispanic Origin? (Specify Yes or No<br>If Yes, specify Cuban, Mexican, Puerlo Rican, etc.)<br>1 □ Yes 2 ☑ No Specify: |                         |                     |              |                                  | )-               | 14. Race - Ar<br>Black, WI<br>Specify: Wh | hite, et | c.   |
| Maryland 21215-0036                       | n 72 hou<br>"natura<br>edical E  | Completed      |  | 15. Decedent's ecify only highest of      |   |                        | 1                            | 6a. Deced                               | lent's Usua<br>kind of wo   | al Occupa<br>ork done o | ation<br>furing mos | st of workin | g                                | 16b. Ki          | ind of Busines                            | ss/Indu  | istry  |
| 12  | withii<br>iene.<br>than  | dwo            | Elementary/Sec   | ondary (0-12)                             | College (   | 1-4or 5+               | +)<br>I                      | lomem                                   |   |                         | ,                   |              |                                  | Own              | Home                                      |          |  |
| 9   | ifiled<br>I Hyg<br>other   | a)             | 17. Father's Name  | (First, Middle, La                        | st)   |                        |                              |   |   |                         | 18. Moth            | er's Name    | (First, Middle                   | , Maiden         | Surname)                                  |          |  |
| <u> a</u>                                 | Aenta<br>Aenta<br>rked<br>tic ev   | To B           | Frank M.   | Stuart                                    |   |                        |                              |   |   |                         | Fern                | Adri         | enne W                           | letze            | <b>2</b> 1                                |          |  |
| ary                                       | should hand hand   | ľi             | 19a. Informant's N   | lame/Relationship                         | (Type. Print)   |                        | 1                            | 19b. Mailin                             | g Address   | (Street a               | and Numb            | er or Rural  | Route Numb                       | er, City o       | or Town, State                            | e, Zip ( | Code)  |
|   | and and n 27   |                | Stuart M   | · ·                                       | / Son   |                        |                              |   |   |                         | ine R               |              | 11e, M                           |                  |   |          |  |
| Baltimore,                                | ges 1<br>t of H<br>if iter<br>or oth   |                | 20a. Method of Dis<br>1 X Burial 2   | sposition  Cremation 3                    | ☐Removal from   | State                  | 20b. Place<br>ceme           | e of Dispos<br>etery, cren              | sition (Nar.<br>natory or o   | me of<br>other plac     | e) :                | Da           | ate                              | 20c. Lo          | ocation - City                            | or Tov   | ın, State  |
| Ë   | tmen<br>tant:  |                |  | 5 ☐ Other (Spe                            |   |                        | Rock                         |   |   |                         |                     | 1/31/        |                                  |                  | shingto                                   |          |  |
| Bal                                       | permit<br>Depar<br>Impor<br>any In   | V. A           | 21. Signature of F   | Conthy                                    | Muna  | 14                     |                              | 5.                                      | 130 W   | /isco                   | nsin                | Ave.         | NW Wa                            | shin             | 's Son<br>gton,                           | DC       | 20016  |
|   |  |                | 23a. Part1. Enter<br>shock, or he  | the disease or co<br>art failure. List on | mplications that  | caused t               | the death. De.               | Do not ente                             | er the mod  | de of dyin              | g, such as          | s cardiac or | respiratory a                    | rrest,           |   |          | Approximate<br>Interval Between<br>Onset and Death |
|   | Physician  |                | Immediate Cause<br>disease or conditi-<br>resulting in death)                            | on  | - u.  |                        | y Arte                       |   | iseas   | se                      |                     |              |                                  |                  |   |          |  |
|   | /Medical<br>Examiner   |                | resulting in death)  | 4   |   |                        | consequen                    |   |   |                         |                     |              |                                  |                  |   |          |  |
| 22  |  | <u>.</u>       | Sequentially list c  | onditions,                                | D   |                        | ry Ede                       |   |   |                         |                     |              |                                  |                  |   | -        |  |
| 74J                                       | nsit   | ij.            | Sequentially list control in the cause. Enter Und Cause (Disease of that initiated even) | lerlying<br>or injury                     |   |                        |                              |   |   |                         |                     |              |                                  |                  |   |          |  |
| ^ ó                                       | icate be executed<br>physician and<br>the burial-transit   | Examiner       | resulting in death)  | Last                                      | CDue to   | (or as a               | consequen                    | ice of):                                |   |                         |                     |              |                                  |                  |   | +        |  |
| 9760                                      | cate be<br>ohysicia<br>the bu  | dical          |  |   | d   |                        |                              |   |   |                         |                     |              |                                  |                  |   | -        |  |
| 0 0                                       | certifica<br>Iding pl  | Med            | IF FEMALE:   |   | 220 Hayon o   | itoomo n               | of prognance                 |   |   |                         | ore or text         | _            |                                  |                  |   |          |  |
| ।/२५/ <i>०</i> ४ <i>७</i><br>ds, P.O. Box | the death<br>/ the atter<br>ched for u   | Physician/Me   | 23b. Was decede in the past 1: 1 Yes 2 9 Unknow  | 2 months?<br>☑No                          |   | birth 2<br>nant at t   | 2 ☐ Fetal de<br>time of deat | eath 3□                                 | Ectopic p<br>Other <i>(sp</i>   |                         |                     |              | <u> </u>                         |                  | 23d. Date of<br>Month                     |          | y<br>Day Year                                      |
| 124<br>s, P.                              | res that<br>igned by<br>be deta  | by Ph          | Part II. Other sign  | ificant condition                         | s contributing to   | death but              | ıt not resultin              | ng in the u                             | nderlying c   | cause giv               | en in Part          | l.           | 23e. Did                         | tobacco          | use contribute                            | e to th  | e cause of death?                                  |
| - Pro                                     | w require<br>been sig<br>should b  | edk            |  |   |   |                        |                              |   |   |                         |                     |              | 1 🗆                              | Yes 2            | No 3□                                     | Proba    | ably 4 Unknown                                     |
| $\mathcal{CF}$ -                          | 2 S  | Completed      |  |   |   |                        |                              |   |   |                         |                     |              | 24a. Was                         |                  | 24b. Were                                 | autop    | sy findings available                              |
| 3 4                                       | The ate his page   | ĕ              |  |   |   |                        |                              |   |   |                         |                     |              | perf<br>1∐ Yes                   | ormed?<br>2 🔼 No | death                                     | 1?       | 2□No   |
| OR(/<br>Vital                             | clan:<br>ertific<br>ctor,  | Be (           | 25. Was case refe<br>examiner?   | erred to medical                          |   |                        |                              |   |   |                         |                     | e of Death   | (Check only                      | one)             |   |          |  |
| 4 AOR (ろた<br>or Vital Rec                 | Physician:<br>this certific<br>ral director,   | 2              | 1  Yes 2 2   |   |   | Inpatien               |                              | /Outpatien                              |   |                         | 4 🗆 14              |              |                                  |                  | 6 □Other (S                               | Specify  | )  |
| Z EO                                      | After Annerg   | in oi          | 27. Manner of Dea<br>1 X Natural   | 5 Pending                                 |   | of Injury              |                              | Bb. Time of<br>Injury                   |   | 28c. Injur<br>Wor       |                     |              | 8d. Describe                     | how inju         | iry occurred                              |          |  |
| 7:00                                      | Attending r death. ector: After oy the fune  | icati          | 2 ☐ Accident<br>3 ☐ Suicide  | investigat<br>6 ☐ Could not               | be 200 Plac   | e of iniu              | ıry - At home                | e farm str                              | M  <br>reet_factor  |                         | Yes 2               |              | 8f Location                      | (Street a        | nd Number o                               | Rura     | Route Number,                                      |
| LIS<br>Divig                              | after Direction by   | Certification: | 4 Homicide   | determine                                 | ed build  | ding, etc.             | . (Specify)                  | , | 001, 100101   | y, oo                   |                     |              | City or To                       | wn, Stat         | e)  | 710101   | Troute Training                                    |
| )<br>100                                  | To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page  | Medical C      | 29a. Certifier<br>(Check only<br>one)  |   | Physician: To the and ma                                    |                        | examination                  |   |   |                         |                     |              |                                  |                  |   |          |  |
|   | To the within 2 To the comple  | Me             | 29b. <del>Signature</del> an   | nd title of certifier                     | 11  |                        |                              |   | 29  | c. Licens               | e number            |              | T                                | 29d. Da          | ate signed (M                             | onth, i  | Day, Year)   |
|   | 10   |                | ▶ 62.  | Lew's                                     | HODO  | O                      | $\times$                     |   |   | D632                    | 285                 |              |                                  | 01/2             | 5/2008                                    |          |  |
|   | 1  |                |  | dress of person wi                        |   |                        |                              |   |   |                         | a Hau               | snero        | va MD                            |                  |   |          |  |
|   | Sta  | ate            | 31. Date filed (Mo   |   | 29.   | Registra               | ar's Signatur                | e                                       |   |                         |                     |              |                                  |                  |   |          |  |
|   | Regist   | rar            | JA   | IN 28 20                                  | 08  | 1048 0                 | K                            | 100                                     | Es .  |                         |                     |              |                                  |                  |   |          |  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Dalton January 24, Pauline 2008 6:15 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sommerford Place Howard Columbia If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🕱 F **Director** 217-44-2682 93 Nov. 4, 1914 Washington, DC Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits ural", or items 23a or 28a-f show Examiner must be notifled at 1 ☐ Yes 2 ▼No Directo Maryland Montgomery Brookeville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19304 Treadway Road 20833 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ∐Yes 2 ⊠Xo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2 No Specify. þ SpecifWhite 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Motor Vehicles/ than Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than the D.C. Government Personalized Tag Specialist D.C. Govern 17. Father's Name (First, Middle, Last) i 1 and 2 should be fil Health and Mental H tem 27 Is marked ott Be Robert Joseph Hellmuth Catherine Bernadette Langley and / 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Mary Dalton Hitt/Daughter 19304 Treadway Road, Brookeville, MD 20833 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Jan. Gate of Heaven Cemetery 4 □ Donation 5 □ Other (Specify) Silver Spring, Maryland 2008 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 50 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Essential Hypertension 30 Years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure, Atrial Fibrillation 1 ☐ Yes ★ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1☐ Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Assisted 1 ☐ Yes 2☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation Living 1 Natural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No + hours after death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hin 24 hours at 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 m.D. D56531 January 25, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Snowden River Pkwy., #301, Columbia, MD 21045

DHMH 17 Rev 1/2001

State

Registrar

Harry Li, MD 31. Date filed (Month, Day, Year)

JAN 28

Division or Vital Records, P.O. Box 68760.

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 25 2008 9:20 P M Curtis T. Ewing /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 6729 Surrey Lane Clarksville 8. Date of Birth (Month, Day, Year Oct. 2, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Georgia 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 12XM 2□ F 1920 Director 87 259 16 5821 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No ठ् MD Clarksville Howard Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 21029 United States or itema 23a 6729 Surrey Lane Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1943-47 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Specify: White altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Research Chemical Engineer Naval Research Lab 4 ia marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be nt of Health and Mental Mary Jane Thaxton William I. Ewing Pages 1 and 2 should ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6729 Surrey Lane Clarksville, MD 21029 M. Elizabeth Ewing/Wife other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Crest Lawn Mem. Gard. 1-30-2008 Marriottsville, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** 20 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed as the burial-transit and Due to (or as a consequence of) Box 68760 attending physician 20 Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy ţ in the past 12 months? Month Day Year 5 Cher (specify) 4 Pregnant at time of death ☐Yes 2☐No detached o the 9 Unknown 9 Unknown ģ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. pe 3 Probably 4 ØUnknown 1 ☐ Yes 2 ☐ No should Completed been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 25 No 1 Tyes 1 ☐ Yes 2 No of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) completely tilled in by the tuneral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? after death. Certification: Division 5 Pending investigation 1 Natural 2 Accident 1 Tes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier sted cause of death (Item 23a) (Type, Print), (D) rumsti. = uphem, 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State JAN 2 9 2008 Registrar

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CHARLES **EASTMAN** JANUARY 27, 2008 23:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RISING SUN CECIL CALVERT MANOR HEALTHCARE CENTER 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Davs Hours Min. Director 87 JULY 20, 1920 PA 222-14-9286 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show ad-al Examiner must be notified at 1 X Yes 2 □ No Director **NEW CASTLE** NEWARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 281 BEVERLY ROAD, APT. B1 19711 by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify. WHITE 3 Widowed 4 Divorced Year or Dates: Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUPPORT PERSON **EDUCATION** d 2 should be filed what and Mental Hygie 7 is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev 2 ARTHUR EASTMAN <u>HELEN\_HENKEL</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONALD HYNSON / FRIEND 8 KNICKERBOCKER DR., NEWARK, DE 19713 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 K remation 3 K emoval from State MAYERDALE CREMATORY 02/01/2008 4 ☐ Donation 5 ☐ Other (Specify) NEWARK, DE 21. Signature of Funeral Service Licensee SPICER-MULLIKIN FUNERAL HOMES, INC. M00840 1000 N. DUPONT PKWY., NEW CASTLE, DE 19720 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one carrier in each line. Immediate Cause (Final disease or condition resulting in death) Physician EMENTIA to (or as a consequence of): /Medical **Examiner** perfension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as consequence of) Examiner disense law requires that the death certificate be executed burial-transi and Due to for as a consiquence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9☐Unknown 9 Unknown cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Uhiknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an 1☐ Yes 2 🗆 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner. Hospital: 1 ☐ Inpatient Other: 2 No ို 1 🗆 Ye 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) ner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

within 24 hours after death

To the Funeral Director:
completely filled in by the Hospital

State

(Check only

30. Name at

29b. Signature and title of certifier

31. Date filed (Month, Day, Ye JAN

Registrar

DHMH 17 Rev 1/2001

erson who completed cause of death (Item 23a) (Type, Print

0

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License numb

signed (Nonth Day, Year)

6

29d. Date

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 9:00 aM Bernard Harden Frve 25 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 5111 Sunnyhills dr. Sunderland Calvert 6. Sex If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 87 230-20-2127 Director 11-26-1920 VA Usual Besidence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10h. County be filed within 72 hours after death with the Marylan ntal Hygiene. so other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 √ Yes 2 No MD Calvert Sunderland 10e. Street and Number 10f. Zip Code 20689 10g. Citizen of What Country? USA Funeral 5111 Sunnyhills 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Armed Foress.

1 Fig. Yes 2 No
If Yes, Give
Year or Dates 948-1953 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Assistant **Hospital** <u>7th grade</u> permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 is marked other i any injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Frye Essie Turner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Juanita Bernice Frye /wife 5111 Sunnyhills Dr. Sunderland MD 20689 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐Removal from State Ft. Lincoln Cemetery 1-30-08 4 □ Donation 5 □ Other (Specify) Brentwood MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Vicensee 3401 Bladensburg Rd. Brentwood MD 20722 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** monerte /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-trar Due to (or as a consequence of): Box 68760 physician Physician/Medical the, IF FEMALE nse If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown P signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobal co use contribute to the cause of death? Records, 9 1 ✓ Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' Division or Vital 2 **X**No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 □ Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one)

10

31. Date filed (Month. Dav. Year State Registrar

29b. Signature and title of certifier

JAN 2 9

Yazdani

2008

29c. License number

29d. Date signed (Month, Day, Year) 8118

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Solomons Island Rd. North Huntingtown MD 20639

32. Registrar's Sign

|                            |   |                     | A 177  | Pepartment of Health and M<br>Certificate of Death                               |   | 9 0 0 S  | 04013  |
|----------------------------|---|---------------------|--|--|---|--|--|
|                            | Physici   | an                  | 1. Decedent's Name (First, Middle, Last)  Darrell Francis Fowler   |  | 2. Date of Death<br>Month                   | <sup>□</sup> 1 6 2 0 0 8                       | 3. Time of Death                                   |
| 7                          | /Medi<br>Examir   |                     | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death   |   | 4c. County of Deat                             | h  |
| 10.5                       |   |                     | Heartland of Adelphi  5. Social Security Number  6. Sex  7. Age (In yrs. last birti  | Adelphi  hday)   If Under 1 Year   If Under 24 Hrs.                              | 8. Date of Birth                            | Prince (                                       |  |
| 300                        | Funeral<br>Director   | ;                   | 579-74-6412 10XM 2 F 52  | rs. Months Days Hours Min.   | sept 16                                     | 1955 DC  | nplace (State or Foreign<br>untry)                 |
|                            | land<br>ow  |                     | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town  |  |   |  | 10d. Inside City Limits                            |
|                            | Ba-f sh   | ctor                | Md Prince Georges Adelph   |  |   |  | 1 AYes 2 No  |
|                            | 3a or 2   | Dire                | 1801 Metzerott Rd  | 10f. Zip Code<br>20783   |   | g. Citizen of What Co<br>. S . A .             | untry?   |
| 36                         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural, or iteme 23a or 28a-f show says injury or other traumatic event, its Medical Examinar must be notified at ance. | by Funeral Director | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Never in U.S. Armed Forces?  1 Never Married 2 Never in U.S.  | 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto | pecify Yes or No-<br>Dican, etc.)           | 14. Race - Ame<br>Black, White<br>Specify: B1a | e, etc.  |
| 2-00                       | 72 houn   | ted !               | 15. Decedent's Education 16a.  | Decedent's Usual Occupation  | 16  | Sb. Kind of Business/                          |  |
| Maryland 21215-0036        | within and the same.  | Completed           | Elementary/Secondary (0-12) College (1-4or 5+)   | (Give kind of work done during most of work life. DO NOT use retired)            |   | )  |  |
| 2<br>ام                    | e filed<br>al Hygie<br>other<br>vent,   | Be Co               | 12th Pri<br>17. Father's Name (First, Middle, Last)  | .nter  | e (First, Middle, Ma                        | Private  aiden Sumame)                         |  |
| ylar                       | Menta<br>Menta<br>Marked  | To E                | Bernard Francis Fowler   | Margare  |   |  |  |
| <u>a</u>                   | nd 2 st<br>alth and<br>27 ts n<br>r traum   |                     | rather   | Mailing Address (Street and Number or Rui<br>341 Woodmont Pl S                   |   |  |  |
| altimore,                  | Pages 1 a<br>nent of Hea<br>ant: If item<br>ary or othe   |                     | cemeter  | Disposition (Name of<br>y, crematory or other place)<br>enham Veteran Jan        |   | oc. Location - City or Cheltenl                |  |
| Balt                       | permit. Departr imports eny injt  |                     | 21. Signature of Funeral Service Licensee Laterne & Montgorerry  | 22. Name and Address of Facility MC 2019 MLK Jr Ave                              |   |  |  |
| 1                          | Physician   |                     | 23a. Part 1. Enter the disease, or complications that dused the dead. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a Myocardial II  |  | or respiratory arres                        |  | Approximate Interval Between Onset and Death  5 MO |
|                            | /Medical<br>Examiner  |                     | Due to (or as a consequence of Atherosclero:   |  | <u>}</u>                                    |  | years  |
|                            | uted<br>d<br>ansit  | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Connective T:  | issue Disorder   |   |  | years  |
| 8760,                      | cate be executed obysicien and the burial-transit   | Ical Exa            | that initiated events resulting in death) Last  Due to (or as a consequence of the conseq | f):  |   |  |  |
| P.O. Box 68                | The law requires that the death certificate be executed tie hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit  | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown  | 3 □Ectopic pregnancy 5 □ Other (specify)   |   | 23d. Date of deli<br>Month                     | very<br>Day Year                                   |
|                            | w requires that<br>been signed b<br>should be deta  | þ                   | Part If. Dther significant conditions contributing to death but not resulting in Congestive Heart Failure  | the underlying cause given in Part I.  |   | cco use contribute to                          | the cause of death?                                |
| Division of Vital Records, | The law requicate hes been page 2 should  | Completed           | Rheumatoid Arthritis   |  | 24a. Was an autopsy performe                | ed? death?                                     | topsy findings available completion of cause of    |
| Z<br>Z                     | ysicion: The<br>is certificate he<br>director, page   | Be                  | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒No  Hospital: 1 ☐ finatient 2 ☐ FB/Out  |  | h (Check only one)                          |  |  |
| on of                      | Attending Physicien:<br>r death.<br>ector: After this certifice<br>by the funeral director, p   | ıtlon: To           | 27. Manner of Death 28a. Date of Injury 28b. Ti  |  | 28d. Describe how                           |  | cify)  |
| Divis                      | ospital or Attendi<br>hours after death.<br>uneral Director: A<br>ly filled in by the ti  | Certification:      | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)   | m, street, factory, office   | 28f. Location (Stre<br>City or Town,        | et and Number or Ru<br>State)                  | ral Route Number,                                  |
|                            | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral   | edicai              | 29a. Certifier (Check only one)  1XCertifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.   | Vor investigation, in my opinion, death occur                                    | and due to the cau<br>red at the time, date | se(s) and manner as<br>e and place, and due    | stated.<br>to the cause(s)                         |
| )                          | To To To To   | Σ                   | 29b. Signature and title of certifier  | 29c. License number  D 1 960 9   | 290   | I. Date signed (Month                          | n, Dey, Year)                                      |
| )                          | (2)   |                     | 30. Name and address of person who completed cause of death (Item 23a) (1  |  | li MD/                                      | 129/2  | 2008   |
| _                          | <b>6</b>  |                     | 3503 Perry Street Mount Rai  |  |   |  |  |
|                            | Sta<br>Registr  | _                   | 31. Date filed (Month, Day, Year)  JAN 2 9 2008  32. Registrar's Signar'e  |  |   |  |  |

|   |                        | 1 - For<br>State<br>Registrar  |                          |  | larylan                 | d / Dep                            |                              | t of He                     | ealth and Moeath                         | lental Hy                          | Reg. No.                 | 2008                            | 04                                    | 0   4          |
|---|------------------------|--|--------------------------|--|-------------------------|------------------------------------|------------------------------|-----------------------------|--|------------------------------------|--------------------------|---------------------------------|---------------------------------------|----------------|
| Phys  | ician                  | 1. Decedent's Name (First, M   |                          |  |                         |                                    |                              |                             |  | 2. Date of Dea<br>Month            | Day                      | Year                            | 3. Time o                             |                |
| /Me   | dical                  | WOODLOW F.   |                          |  | 1                       |                                    | 4h Cihr                      | Town or                     | Location of Death                        | Januar                             |                          | 2008 County of Death            | 6:35                                  | P <sup>M</sup> |
| Exan  | niner                  |  | _                        |  |                         |                                    | Crof                         |                             | Location of Death                        |                                    |                          | nne Aru                         |                                       |                |
| Funer   | al                     | Crofton Con 5. Social Security Number  | 6. Se                    |  |                         | last birthday,                     | If Under                     | 1 Year                      | If Under 24 Hrs.                         | 8. Date of Birt                    | h                        | O Diet                          | place (State ountry)                  | or Foreign     |
| Directo   |                        | 579-05-9104  |                          | <b>X</b> M 2□ F  | 90                      | Yrs.                               | Months                       | Days                        | Hours Min.                               | July 12                            | 19                       | 17 Vir                          | ginia                                 |                |
| and   |                        | Usual Residence of Deceder<br>10a. State 10b. Co   |                          |  | 10c. Cit                | y, Town or L                       | ocation                      |                             |  |                                    |                          |                                 | 10d. Inside C                         | City Limits    |
| Mary<br>1 • h   | ō                      | MD Ann   | e Aru                    | ndel   |                         | Gambr                              | ille                         |                             |  |                                    |                          |                                 | 1 🗌 Yes                               | 3 <u>4</u> □No |
| r 28e   | Director               | 10e. Street and Number   | CIMU                     | IIGCI  | 1,                      | Gariot                             | 10f. Zip                     | Code                        |  |                                    | 10g. Citize              | en of What Cou                  | untry?                                |                |
| after death with the Marylan or Iteme 23e or 28e-f show collines.   | a D                    | 730 Route 3  | Sout                     | h  |                         |                                    |                              | 2105                        | 54                                       |                                    |                          | USA                             |                                       |                |
| - dea   | Funeral                | 11. Marital Status   |                          | 12. Was Decedent   | Ever in U.              | S. 13.                             | Was Deced                    | ent of His                  | spanic Origin? (Sp<br>n, Mexican, Puerto | ecify Yes or No<br>Rican, etc.)    | - 14                     | 4. Race - Amer<br>Black, White  |                                       |                |
| hours after death with the Maryland turel; or Items 23s or 28s-1 show   | by FL                  |  |                          | 1  | No 19                   | 44-                                | 1 ☐ Yes 2                    |                             |  | ,                                  |                          | Specify:                        | White                                 | :              |
| 72 hours<br>"natural",  | Completed by           | 15. Dec  | edent's Edu              | cation   | 1341                    | 16a. Dece                          | dent's Usua                  | I Decupa                    | tion                                     |                                    | 16b. Kind                | d of Business/i                 | ndustry                               |                |
| d within 72 hours af<br>giene.<br>rr than "natural", or<br>the Madical Exam   | ole                    | (Specify only h  |                          | e completed) College (1-4or                                | 5+)                     | (Give                              | kind of wor<br>DO NOT us     | rk done di<br>se retired)   | uring most of work                       | ing                                |                          |                                 |                                       |                |
|   | Con                    | 12   |                          |  |                         | Book                               | Binde                        |                             | per Cutte                                |                                    |                          | rnment                          |                                       |                |
| wild be filed<br>Mental Hygiarked other   | Be (                   | 17. Father's Name (First, Mic  |                          |  |                         |                                    |                              |                             | 18. Mother's Nam                         |                                    |                          |                                 |                                       |                |
| Mer   | ို                     |  |                          |  |                         |                                    |                              |                             | Lessie E                                 |                                    |                          |                                 |                                       |                |
| id 2 shoul<br>ith and Ma<br>ith and Mari<br>27 is mari  |                        | 19a. Informant's Name/Rela   | G.                       |  |                         |                                    |                              |                             | nd Number or Run                         |                                    |                          |                                 | ip Code)                              |                |
| C = 01 L  |                        | Linda M. Mu  | rray/                    | Daugnter   | 20b. P                  | lace of Disp                       | Sabra<br>osition (Nam        | ne of                       |  | Date                               | 21114<br>20c. Loc        | 4<br>ation - City or 1          | Town, State                           |                |
| 9 0 = 5   |                        | 1 XBurial 2 Crema<br>4 Donation 5 Oth  |                          | lemoval from State   | <b>)</b>                | <sub>emetery, cire</sub><br>kemont |                              |                             |  | /2008                              |                          |                                 |                                       | )              |
| # Fre   |                        | 21. Signature of Funeral Sec   |                          | <u> </u>   | M01                     |                                    |                              |                             | s of Facility Bea                        | -                                  |                          |                                 | .10, 11                               |                |
| P P P P P P P P P P P P P P P P P P P   | 30                     | 1/orin   | LA                       | درال   | 1101                    |                                    |                              |                             | ain Hwy.                                 |                                    |                          |                                 |                                       |                |
| Physicia<br>/Medica<br>Examine  | al                     | 23a. Part   Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | List only of             | Due to (or as  | ine.  Lon  s a conseq   | uence of):                         | EU M.                        | ,                           |  | or respiratory ai                  | rrest,                   |                                 | Approxima<br>Interval Be<br>Onset and | tween          |
| death certificate be executed death certificate be executed e ettending physician and dor use as the burial-transit | Physician/Medical Exar | resulting in death) Last   |                          | Due to (or as  Due to (or as  Due to (or as  Due to (or as | e of pregna<br>2 ∐ Feta | incy                               | ⊒Ectopic pre                 |                             |  |                                    | 23                       | 3d. Date of deli                |                                       | Year           |
| 5 t t g   | NS/                    | 1  Yes 2 No<br>9  Unknown  |                          | 9□ Unknown   |                         |                                    | _ 0.1.0. (0,0.0              |                             |  |                                    |                          |                                 |                                       |                |
| g & 90 8  | > P                    | Part II. Other significant con   | ditions co               | ntributing to death:                                       | but not res             | ulting in the u                    | underlying ca                | ause give                   | n in Part I.                             | 23e. Did to                        | obacco us                | e contribute to                 | the cause of                          | death?         |
| w require<br>been sly<br>should b   | ed                     | Temphral V   | u into                   | r and  | 1-2                     |                                    |                              |                             |  | 10                                 | Yes 25                   | ÛNo 3□Pro                       | obably 4 🗌                            | Unknown        |
| ilclan: The law requires certificate hes been sign rector, page 2 should be   | Completed by           | 1  |                          |  |                         |                                    |                              |                             |  | 24a. Was<br>autop                  | osy                      |                                 | topsy findings<br>ompletion of a      | available      |
|   | ွ                      |  |                          |  |                         |                                    |                              |                             |  |                                    | rmed?<br>20%No           | death?<br>1 ☐ Yes               | 2) No                                 |                |
| Physician: The law this certificete hes trail director, page 2 s  | Be                     |  | -                        | lospital:  |                         |                                    |                              | 000                         | 26. Place of Deat                        | h (Check only o                    | one)                     |                                 |                                       |                |
| this di   | <u>ار</u>              |  |                          | 1 Inpat  |                         | ER/Outpatie<br>28b. Time of        |                              |                             | 4 Nursing no                             | me 5 Resident                      |                          |                                 | eify)                                 |                |
| After   | atlon                  | 1 Natural 5 P  | ending<br>restigation    | (Month, D  | ay Year)                | Injury                             | M                            | 8c. Injury<br>Work<br>1 □ Y | ?<br>'es 2 \_No                          | Zod. Describe i                    | now injury               | occurred                        |                                       |                |
| s after death. Il Director: Afte  | Certification:         | 3 ☐ Suicide 6 ☐ C<br>4 ☐ Homicide de   | ould not be<br>termined  | 28e. Place of In<br>building, e                            | jury - At ho            |                                    | reet, factory                | , office                    |  | 28f. Location (S<br>City or Tov    | Street and<br>wn, State) | Number or Ru                    | ral Route Nur                         | nber,          |
| To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the          | Medical                |  | ifying Phy<br>ical Exami | nician: To the businer: On the basis of and manner s       | of examina              | wladge, deal<br>tion and/or in     | th octumed to<br>estigation, | ut the time<br>in my op     | e, data and plane;<br>inion, death occur | and due to the<br>red at the time, | cause(s) a<br>date and p | ind manner as<br>place, and due | stated.<br>to the cause(              | s)             |
| To the within 2 To the comple   | Me                     | 29b. Signature and title   | rtifier                  |  |                         |                                    | 29c                          | License                     | number                                   |                                    | 29d. Date                | signed (Month                   | n, Day, Year)                         |                |
|   |                        |  | 1                        |  |                         |                                    | D                            | 000                         | 38955                                    | -                                  | 1/2                      | 9/2008                          | -                                     |                |
| (3)+1   |                        | 30. Name and address of pe   | _                        | ompleted cause of  | death (Item             | 23a) (Type                         | Print)                       | 40                          | 08938<br>UG/ei                           | RUCA                               |                          | MIDO                            | 21061                                 | /              |
|   | State                  | 31. Date filed (Month, Day,  | nns                      | 32. Regist   | rar's Signa             | tur                                | 2                            | 1 20                        | V_V/E/                                   | <u> </u>                           | , , , , ,                | 1/3                             | /                                     |                |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Loretta Fioretti January 25, 2008 2:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5306 Westport Road Chevy Chase Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 F Director 577-54-7712 09/02/1940 Croatía Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show eny Injury or other traumetic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Montgomery Chevy Chase Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5306 Westport Road 20815 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: Italian þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dental Hygenist Dental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alfonso A. Viola Olga S. Domic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Viola Cordova/Daughter 5306 Westport Road Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Buria! 2 Cremation 3 ☐ Removal from State Jan. 28,08 | Falls Church, VA National Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Line 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disclase, or complications that fail ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail are. List only one cause only a hime. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 9 Months Metastatic Lung Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter oncoming Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Pregnant at time of death 5 Other (specify) detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1X Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Certification: To

Division or Vital Records, P.O. Box 68760 the Hospital or Attending I hin 24 hours after death. the Funeral Director; After

|                |  |                                |           |  |                         |                |   | 1□ Yes                        | 2 😾 No                   | 1 ☐ Yes              | 2 □ No           |  |
|----------------|--|--------------------------------|-----------|--|-------------------------|----------------|---|-------------------------------|--------------------------|----------------------|------------------|--|
| 25.            | Was case referre<br>examiner?            | d to medical                   |           |  |                         |                | 26. Place of De                           | eath (Check only one)         |                          |                      |                  |  |
| 1 ☐ Yes 2 ☑ No |  |                                |           |  |                         | Horne 5 ₹ Resi | dence 6                                   | 3 □Other (Speci               | ify)                     |                      |                  |  |
| 27.            | Manner of Death 1 ☑ Natural 2 ☐ Accident | 5 Pending investigation        | (A        | ate of Injury<br>Month, Day Year)              | 28b. Time of<br>Injury  | М              | 28c. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No | 28d. Describe                 | how injury               | y occurred           |                  |  |
|                | 3 ☐ Suicide<br>4 ☐ Homicide              | 6 ☐ Could not be<br>determined | 1 28e. Pl | ace of injury - At ho<br>uilding, etc. (Specif | ome, farm, stree<br>(y) | t, facto       | ory, office                               | 28f. Location (<br>City or To | Street and<br>wn, State) | d Number or Run<br>) | al Route Number, |  |

January 25, 2008

| 29a. Certifier     | 1 ☐ Certifying Physic | cian: 1  | To the best | t of my knowledge, death occu  | irred at the time, date and place, and due to the  | ne cause(s) and manner as stated.          |
|--------------------|-----------------------|----------|-------------|--------------------------------|--|--|
| (Check only        | 2 ☐ Medical Examine   | er: On   | the basis   | of examination and/or investig | ation, in my opinion, death occurred at the tim  | e, date and place, and due to the cause(s) |
| one)               |                       | and      | nanner s    | tated.                         | and the state of t | o, auto and place, and due to the oddse(s) |
|                    |                       | <b>-</b> | 44          | /                              |  |  |
| 29b. Signature and | title of certifie     | 1 //     |             |                                | 29c. License number  | 29d. Date signed (Month, Day, Year)        |

30. Name and address of rson who completed cause of death (Item 23a) (Type, Print)

Frederick P. Smith MD 5454 Wisconsin Ave. #1300 Chevy Chase, MD 20815

State Registrar 31. Date filed (Month, Day, Year) **JAN 28** 2008



within 24 hours a

08-00669 Gennaro J. Fato

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| ennaro J. Fato   |                | State Registrar  | ate of Maryland                                      |                       | artment of<br><i>rtificate of</i>       |                                | and       | Menta         | Hygiene                           |                            | . No. 200                                | 8 0401                            |
|--|----------------|--|--|-----------------------|---|--------------------------------|-----------|---------------|-----------------------------------|----------------------------|--|-----------------------------------|
| Physicia<br>Medical Exami  | an/            | 1. Decedent's Name (First, Middl   | le,Last)<br>nnaro James Fat                          | .0                    | -                                       |                                |           |               | 2. Date of Month                  |                            | Day Year<br>, 2008                       | 3. Time of Death<br>2216 hrs      |
|  |                | 4a. Facility Name (if not institution 3628 Martin Dairy Circ                                       | on, give street and number                           |                       | 4                                       | b. City, Tov                   | vn, or Lo | cation of D   |                                   | , <u>20</u>                | 4c. County of Death                      | )                                 |
| Funeral  |                | Social Security Number   |  | je (In yrs. la        | ast birthday)                           | Olney<br>If Under              | 1 Year    | If Under 2    | 4Hrs. 8. Date                     | of Birth                   | (MM/DD/YYYY) 9. Bir                      |                                   |
| Director   |                | 578-54-8236  | 1 X M 2 F  | . 74                  | Yrs.                                    | Months                         | Days      | Hours         | Min. 08                           | /30/                       | 1933 Foreig                              | on<br>ountry) Italy               |
| any  |                | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City,            | Town or Location                        | on                             |           |               |                                   |                            |  | 10d. Inside City Limits           |
| re Maryland<br>or 28a-f show any<br>fied at once.  | ē              |  | gomery   |                       |   |                                | 011       | ney           |                                   |                            |  | 1 Yes 2 X No                      |
| with the Maryland<br>ns 23a or 28a-f sho<br>be notified at smee.   | Director       | 10e. Street and Number 3628 Martins I  | Dairy Circle   |                       |   | 10f. Zip Ci                    |           | 0832          |                                   | 10                         | g. Citizen of What Cou<br>U.S.A          |                                   |
| th with tems 23s   | Funeral        | 11. Marital Status  1 Never Married 2 X M.   | 12. Was Decedent                                     |                       |   |                                | of Hispa  | anic Origin   | ? (Specify Yes<br>uerto Rican, et |                            |  | ican Indian, Black,               |
| 0036 within 72 hours after death with the Maryland jene. rer thau "natural", or items 23a or 28a-f she Medical, Examiner must be notified at sence |                |  | 1 Yes 2  | X No                  |   | Yes 2 X                        |           |               | ,                                 | ,                          |  | White                             |
| hours a<br>'natura<br>Examir   | ted by         | 15. Decedent's Education (Spe  |  |                       | 16a. Decedent                           | t's Usual Oc<br>ost of working |           |               |                                   |                            | 16b. Kind of Business/                   | Industry                          |
| 036<br>ithin 72<br>ine.<br>r than "  | Completed      | Elementary/Secondary (0-12)  | College (1-4 or                                      | 5+)                   |   | Self E                         | mploy     | yed           |                                   |                            | Upho1ste:                                | ry Business                       |
| P 2 2 2 3  | Be Co          | 17. Father's Name (First, Middle,  |  |                       |   |                                | 18        |               |                                   |                            | aiden Surname)                           |                                   |
|  | To B           | Saverio 19a. Informant's Name/Relations  |  |                       | 19b. Mailing                            | Address                        | (Street a |               | Amelia Ma<br>r or Rural Rou       |                            | per, City or Town, State                 | e, Zip Code)                      |
| <b>∑</b> 2=2≡  |                | Fatmira Fato - S   | Spouse   | 20b.                  | 3628 M                                  |                                |           |               | ole, Olne                         | ey, M                      | aryland 2083:<br>20c. Location - City of |                                   |
| imore, MD 2<br>Pages I and 2 shou<br>ment of Health and I<br>lant: If item 27 is r<br>or other traumatic   |                | 1 X Burial 2 Cremation 4 Donation 5 Other Sp   | n 3 Removal from St                                  | iaic                  | crematory or oth<br>te of Hea           |                                | meter     | v             | 01/28/20                          | 108                        | Silver Sprin                             | ng. Marvland                      |
| Baltimore,<br>permit. Pages I and<br>Department of Heal<br>Important: If iten  |                | 21. Signature of Funeral S rvin  | Licensee   | 4                     | 22. N                                   | ame and A                      | ddress    | f Facility    | Hines-H                           | Rinal                      | di Funeral H                             | ome, Inc.                         |
| Physician  |                | 23a. Part I. Enter the disease, or   |  | the death             |   |                                |           |               |                                   |                            | ver Spring, 1<br>st, shock, or heart     | Approximate Interval              |
| /Medical<br>Examiner   | H              | Immediate Cause (Final disease or condition resulting in death)                                    | a. Shotgun Woun                                      |                       |   |                                |           |               |                                   |                            |  | Between Onset and<br>Death        |
| . *  |                | Sequentially list conditions,  | Due to (or as a cons                                 | sequence o            | or):<br>                                |                                |           |               |                                   |                            |  |                                   |
|  | Examiner       | if any, leading to immediate<br>cause. Enter Underlying Cause<br>(Disease or injury that initiated | e  |                       |   |                                |           |               |                                   |                            |  |                                   |
| nd nted nd ransit  | Exa            | events resulting in death) Last  | Due to (or as a cons                                 | equence o             | of):                                    |                                |           |               |                                   |                            |  |                                   |
| 50, te be executed nysician and burial - transit   | ledical        | UNPENDED   | AMENDED  |                       |   |                                |           |               |                                   |                            |  |                                   |
| Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi   | an/Me          | IF FEMALE:<br>23b. Was decedent pregnant in the<br>past 12 months?                                 | Live birti   |                       | 2 Fe                                    | tal death                      | 3         | Ectopic p     | regnancy                          |                            | 23d. Date of delive<br>Month             | ry<br>Day Year                    |
| Box 6876 ne death certificate the attending phy hed for use as the   | Physician/N    |  | known g Unknown                                      | t time of de          | eath 5 Otl                              | her (Specif                    | y)        |               |                                   |                            |  |                                   |
| hat the  | by Ph          | Part II. Other significant condit  | tions contributing to dea                            | th but not r          | resulting in the u                      | inderlying c                   | ause giv  | en in Part    |                                   | -                          | pacco use contribute to                  | the cause of death?               |
| rds, P   | eted           |  |  |                       |   |                                |           |               | — Ulasi                           | . Was a                    | n 24b. Were a                            | utopsy findings available         |
| of Vital Records, ng Physician: The Live require Niter this certificate has been si neral director, page Eshould b                                 | Completed      |  |  |                       | <del></del>                             |                                |           |               | —  <br>1 <b>▽</b>                 | autops<br>perfori<br>Yes 2 | med? death?                              | completion of cause of<br>es 2 No |
| Vital Rec<br>sysician: Te<br>this certificate<br>director, page  | å              | 25. Was case referred to medica examiner?  | Hospital   | 2                     | ER/Outpatient                           |                                |           | 46            | heck only one)                    |                            | Residence 6 V Other                      | - Coope                           |
| n of V<br>ding Phys<br><br>After this  | n: ٦           | 1 ✓ Yes 2 No<br>27. Manner of Death  | 28a. Date of Inj<br>(Month, Day,                     | ent 2<br>ury<br>Year) | 28b. Time of I                          |                                |           | at Work?      |                                   | scribe h                   | ow injury occurred                       | er: Scene                         |
| Division<br>ra or Attendii<br>rs after death.<br>at Director: /  | catio          | 1 Natural 5 Pend 2 Accident Inve   | stigation Jan 23, 2008                               | 3                     | FOUND:<br>2156 hrs<br>nome, farm, stree |                                |           | es 2 V N      |                                   |                            |  | ural Route Number, City           |
| Divis  | Certification: |  | id not be  |                       | residence                               | st, ractory, c                 | onice bu  | ilaling, etc. | or 1                              | own, St                    |  |                                   |
| = 2 Z = =  |                |  | hysician: To the best of naminer:On the basis of exa |                       |   |                                |           |               |                                   |                            |  |                                   |
| To the within 7 To the comple  | Medical        | 29b. Signature and title of certific   | and manner stated                                    |                       |   |                                | License   | number        |                                   |                            | 29d. Date signed (M                      |                                   |
| 10   |                | Theoden W  | 1 74 × TI  | 21, 11                | · M                                     |                                | O.C.N     | 1.E.          | OCME                              |                            | January 25, 200                          | 08                                |
|  |                | <ol> <li>Name and address of persor</li> <li>Theodore M. King, Jr.</li> </ol>                      | 1/   |                       | ,                                       | 111 Pen                        | n Stre    | et, Balti     | more, MD                          | 21201                      |  |                                   |
| So<br>Regis  | ate<br>trar    | 31. Date filed (Month, Day, Year)  | 8 2008 32. F gistra                                  | ar's Signat           | Urs Apr                                 | will)                          |           |               |                                   |                            |  |                                   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 20 **Physician** Month Year effren reen 0305M Januar-2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hopkins 1 fmor Mospitz ohns Social Security Number 6. Sex Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Mohth, Day, Ye 01/11/1966 9. Birthplace (State or Foreign **Funeral** Hours 1☐M 2☐F Days Min. 42 Director 578-96-5126 Washington, DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov 1. ☐Yes 2 ☐ No Director Montgarery Caithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be 8609 Hawk Terrance 20886 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify 2 Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Mme Disable 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Pearlie Mae Williams ပို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8609 Hawk Terrance; Gaithersburg, Maryland 20886 IaShawntelle L. Green - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Purial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 02/04/2008 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licensee 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part1. Art r the disease, or complications t shock, or heart failure. List only one cause his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, used neach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due o (or as a consequence of): month disease or condition resulting in death) /Medical Examiner toury an Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or at a contequence of): Examiner sician and burial-transit Jen Sis Due to (of as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ ★\*\*

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1∐ Yes 2 No or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To After this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deal 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death Item 23a) (Type, Print) 600 North Wolfe Street Boltmore MD 21287 MD 31. Date filed (Month, Day, 1 32. Registrar's Signature Year) State

DHMH 17 Rev 1/2001

Registrar

JAN 2 9

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 01-27-2008 Year **Physician** CLYDE D. GREEN 10:05 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BRADFORD OAKS NURSING & REHAB. CTR. CLINTON PRINCE GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02-23-1940 9. Birthplace (State or Foreign Country) Wash., DC **Funeral** Months Days Hours Min 1**½** M 2 □ F 67 Director 578-50-2623 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h Counts 10d. Inside City Limits "natural", or items 23a or 28a-f show clical Examiner must be notified at 1 T¥Yes 2 □ No Director D.C. Washington with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 562 23rd. Place, N.E. 20002 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Armed Forces? 1¥ Yes 2 □ No Black, White, etc. 1¥ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: à Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) and Mental Hygiene. Is marked other than US Government Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 2 Clyde Green Clara Hampton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of item 27 l Wash., Shirley E. Cooley/companion 562 23rd. Place, N.E. DC 20002 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 01-30-2008 Pages 1 <u>#</u> 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, Maryland Riverdale Pk.Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mary Hedgman Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 9 disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 9☐Unknown Year Day 5 Other (specify) P.O. | ed by the a detached f 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has b 24a. Was an autopsy performed? 2-1 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: Other: 4 ≯Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 ☐ Yes 1 ☐ Innatient 2 ER/Outpatient 3 DOA After this 27. Manper of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural (Month, Day Year) lospital or Attendir 4 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar

DHMH 17 Rev 1/2001

701 Wungston
32. Registrar's Signature 31. Date filed (Month, Day, Year)

11701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 3 0 2008

awhine

29b. Signature and title of

ertifie

J Caine

29c, License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

| Reg. No | 0 | 0 |
|---------|---|---|
|---------|---|---|

| Physician |
|-----------|
| /Medical  |
| Examiner  |

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura!" --- any injury or other traumatic everage.

Physician /Medical Examiner

the death certificate be executed attending physician and I for use as the burial-trar Hospital or Attending 24 hours after death. Director:

Division or Vital Records. P.O. Box 68760.

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 24, Lenwood Preston Howard, Jr. 2008 1:21 P. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Cheverly Prince George's Prince George's Hospital Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 04/05/31 Year) 76 Months Days Hours Min 1**☆**M 2□F 577-38-0327 Orange, Va. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits Washington D.C. 1 ☐ Yes 2 XNo Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20019 U.S.A. 238 33rd St., N.E. Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2 🗓 No Specify: Specify 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 11th College (1-4or 5+) Valet/Presser Men's Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Rebecca Elizabeth Gordon Lenwood Preston Howard, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 238 33rd St., N.E., Washington, D.C. 20019 Lue N. Howard/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/02/08 Brentwood, Maryland Ft. Lincoln Cem. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility H.S.Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 any W. s. May 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Hypoxic Encephalopathy disease or condition resulting in death) Due to (or as a consequence of) Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Ischemic Cardiomyopathy resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autonsy perform 2, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Inpatient 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated 29d. Date signed (Monty, Day, Year) 29b. Signature and title of certifie 303/8 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) James/Catevenis,M.D. 3001 Hospital Drive,Cheverly,Maryland 20785 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 9 2008 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Month **Physician** HNUAP 3607 Johnnie V. Haselby, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** GLEN BURNIE WASHINGTON Anne MEDICAL ( BACTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 M 2 F 88 Indiana 24, 394-38-5220 Apr. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hyglene. ortant: If item 27 Is marked other than "natural", or Items 23a or 28a-5 show injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2000 Directo MD Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21054 2607 Chapel Lake Dr. #105 USA 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No <u>ک</u> Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Colonel-USAF U. S. Military 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hazel Hiatt Firman Haselby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Marjorie M. Haselby/Wife 2607 Chapel Lake Dr. #105 Gambrills, MD 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If itel any Injury or oth 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Mem. Gards. 1/30/2008 Davidsonville, MD 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licenses ern Kada Bowie, MD 20715 6512 NW Crain Hwy. Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Examiner EBRONASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit Due to (or as a consequence of): physician the burial Box 68760. Physician/Medical as aftending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy 1 Live birth in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2∏ No 3 Probably 4 🗹 Unknown 1 TYes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed res 2 No Division or Vital 1□ Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 inpatient 2 ER/Outpatient 2 3□ DQA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifier Date signed (Month, Day, Year) e roleted cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month, Day, Yea Registra

30 Marie and address of person who cor



evise

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death O O 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Edgar Osborne Hanley 10:10<sup>P</sup> 25, 2008 /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth
(Month, Day, Year)
Jan. 9, 192 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 MM 2□ F 088-14-7151 1923 Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1X Yes 2 □ No Director Maryland Montgomery North Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or edical Examiner must be 11700 Old Georgetown Road, Apt. 20852 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black ð WWII 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Mechanical Engineer Federal Government nd 2 should be filed valth and Mental Hygid 27 Is marked other¹r r traumatic event, ∰ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be thent of Health and Menta Edgar Bernard Hanley Charlotte Palmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Apt. 605 19a. Informant's Name/Relationship (Type. Print) Shirley N. Hanley/Wife 11700 Old Georgetown Road, N. Bethesda , MD 20852 If item 27 or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Jan. 26. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or Metropolitan Crematory 4 Donation 5 Dother (Specify) 2008 Alexandria, Virginia 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 5 500 University Blvd. W., Silver Spring. ورس 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Rilateral Enermonia /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): wortholdy list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death o. 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> Records, 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an filled in by the funeral director, page 2 2 No Vital Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certification: To 1 Tyes 1 Npatient 2 ER/Outpatient 3□ DOA o 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hin 24 hours after death the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ဂ္ဂ MB D0062167 125108 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hossein Akhondi, MD 8600 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Month, Day, Year) . Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 28 2008

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|                            |   |                    | Please T   | -   |  |                                | . Ensure All C  | •                               | _                     |                                 |  |
|----------------------------|---|--------------------|--|---|--|--------------------------------|---|---------------------------------|-----------------------|---------------------------------|--|
|                            |   |                    | For<br>State<br>Registrar  | State of Ma                                 |  | artment of F<br>rtificate of   | lealth and Men<br><i>Death</i>                        |                                 | 2008                  | 04022                           |  |
|                            |   |                    | Decedent's Name (First, Middle, Last)  |   |  |                                |   | Date of Death                   |                       | 3. Time of Death                |  |
| 20                         | Physici<br>/Medic   |                    | Sara Lewis Hurley  |   |  |                                |   |                                 | 3 2008                | 7:40 P M                        |  |
|                            | Examin  |                    | 4a. Facility Name (If not institution, give s                                    | treet and number)                           |  | 4b. City, Town, o              | r Location of Death                                   |                                 | 4c. County of Dea     | th                              |  |
| 3*3                        |   |                    | Chesapeake Woods C   | Center                                      |  | Cambrid                        |   |                                 | Dorchest              | er                              |  |
| A.                         | Funeral   | 0                  | 5. Social Security Number 6. Sex 1 1 - 1 2 7 6                                   | 7. Ag                                       | (In yrs. last birthday)<br>85 Yrs.       | If Under 1 Year<br>Months Days | Hours Min /   | Date of Birth<br>Month, Day, Ye | 9. Bin<br>2022 Max    | hplace (State or Foreign        |  |
|                            | Director  |                    | Usual Residence of Decedent  |   | 0.5                                      | l                              | April 18,1922 Ma                                      |                                 |                       |                                 |  |
|                            | how   |                    | 10a. State 10b. County   |   | 10c. City, Town or Lo                    | ocation                        |   |                                 |                       | 10d. Inside City Limits         |  |
| _                          | Ba-1 e  | Director           | Maryland Dorcheste   | r   | Cambrid                                  | ge                             |   |                                 |                       | 1 X Yes 2 No                    |  |
| 7                          | within 72 hours after death with the Maryland<br>sne.<br>Then "natural", or tiems 28a or 28a-f ehow<br>na Medical Examinar mant be notified at  |                    | 10e. Street and Number   |   |  | 10f. Zip Code                  | 610   | 10g.                            | Citizen of What Co    | ountry?                         |  |
| ζ                          | s 23s   | Funeral            | 525 Glenburn Avenu   | I E<br>I 2. Was Decedent                    | Tues in U.S. 10                          |                                | .613  | Van an Na                       | USA<br>14. Race - Ame | vican ladiae                    |  |
| 3                          | ttem<br>trem  | E L                | 11. Marital Status  1 ☐ Never Married 2 ☐ Married                                | Armed Forces?                               | ever in U.S.                             | If Yes, specify Cub            | Hispanic Origin? (Specify<br>an, Mexican, Puerto Rica | n, etc.)                        | Black, White          |                                 |  |
| 338                        | urs af  | by                 | 3 XWidowed 4 □ Divorced  | If Yes, Give<br>Year or Dates:              |  | 1□Yes 2X No                    | Specify:  |                                 | Specify: V            | Mhite                           |  |
| 21215-0036                 | 72 ho   | Completed by       | 15. Decedent's Educ<br>(Specify only highest grade                               |   | 16a. Dece                                | dent's Usual Occup             | pation<br>during most of working                      | 16b                             | . Kind of Business    | /Industry                       |  |
| 2                          | thin 7  | np<br>e            | Elementary/Secondary (0-12)  | College (1-4or 5                            | life.                                    | DO NOT use retire              | d)  |                                 |                       |                                 |  |
| 2                          | ygien<br>ygien<br>her th  | ပ်                 | 11   |   | Home                                     | emaker                         |   |                                 | Own Ho                | ome                             |  |
| Maryland                   | be fil<br>d off   | Be                 | 17. Father's Name (First, Middle, Last) Frank Lewis                              |   |  |                                | 18. Mother's Name (Fil                                |                                 | den Sumame)           |                                 |  |
| <u> </u>                   | hould<br>d Mer<br>nark<br>natic   | 2                  | 19a. Informant's Name/Relationship (Typ  | na Grintl                                   | 10b Maili                                | na Addrona /Ctroot             | Blanche Mu  |                                 | hu or Town State      | Zin Cada)                       |  |
| <u>N</u>                   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Hygiene 21 is marked other than "natural" or them and the notified at encilling an only injury or other traumatic event, the Medical Examination made by notified at once. | 1                  | Donald M. Hurley,  |   |  |                                | 15, Mardela   |                                 | •                     |                                 |  |
| <u>ත</u>                   | is 1 and 2:<br>of Health ar<br>item 27 is<br>other trace  | 1 8                | 20a. Method of Disposition   | 01.   | 20b. Place of Dispo                      |                                |   |                                 | Location - City or    |                                 |  |
| Baltimore,                 | Pages<br>ent of<br>nt: if i   |                    | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)              | emoval from State                           | St. Paul                                 |                                | 1   | 008 Vi                          | enna, Mai             | cv1 and                         |  |
| a<br>E                     | mit. partm<br>porta<br>porta  |                    | 21. Signature of Funeral Service Unions  | 000   | 25                                       | Name and Addre                 | ess of Facility                                       |                                 |                       |                                 |  |
| ä                          | F G E G   |                    | senace of  | alle  |  | eller Fun<br>06 Main S         | eral Home,<br>treet, East                             | P. O. Bo<br>New Ma              | ox 207,<br>rket, MD   | 21631                           |  |
| - 2                        |   |                    | 234. Party. Enter the disease, or complice shock, or heart failure. List only on | cations that caused<br>le cause on each lin | the death. Do not ent                    | er the mode of dyi             | ng, such as cardiac or res                            | spiratory arrest,               |                       | Approximate<br>Interval Between |  |
| 1                          | Physician   |                    | Immediate Cause (Final disease or condition                                      | cono  | gestive                                  | heart                          | failure   |                                 |                       | Onset and Death                 |  |
|                            | /Medical<br>Examiner  |                    | resulting in death)  | Due to (or as                               | a consequence of):                       |                                | failure   |                                 |                       | /                               |  |
| 10                         | Examiner  | -                  | Sequentially list conditions, if any, leading to immediate                       | atri  | a consequence of):                       | Matio                          | 7   |                                 |                       | 104exs                          |  |
|                            | ted<br>nsit   | Examiner           | Cause (Disease or injury   | Due to (01 as                               | a consequence on.                        |                                |   |                                 |                       |                                 |  |
| ~                          | e be executed<br>sicien and<br>burial-transit   | Exar               | that initiated events c<br>resulting in death) Last                              | Due to (or as                               | a consequence of):                       |                                |   |                                 |                       |                                 |  |
|                            | sicie<br>e buri   | 70                 |  | l   |  |                                |   |                                 |                       |                                 |  |
| 68                         | tificat<br>ng phy<br>as th  | ledi               | l  |   |  |                                |   |                                 |                       |                                 |  |
| ŏ                          | th cer<br>tendir<br>or use  | an/h               | 230. was decedent pregnant   | 3c. If yes, outcome<br>1 ☐ Live birth       |  | Ectopic pregnanc               | y   |                                 | 23d. Date of de       |                                 |  |
| P.O. Box 68                | e dea<br>the at<br>hed fo   | by Physician/Medic | in the past 12 months?<br>1 □ Yes 2 ☑No<br>9 □ Unknown                           | 4 Pregnant at<br>9 Unknown                  |  | Other (specify)                |   |                                 | Month                 | Day Year                        |  |
| <u>م</u> .                 | that the ed by detect   | Ph                 | Part II. Other significant conditions con  | tributing to death b                        | ut not resulting in the u                | nderiving cause giv            | ven in Part I.  | 23e. Did tobaco                 | co use contribute to  | the cause of death?             |  |
| ds,                        | uires<br>sign   |                    |  |   | son's d                                  |                                |   | 1 ☐ Yes                         | 210No 3 P             | robably 4 Unknown               |  |
| CO                         | w req   | lete               |  |   |  |                                |   | 24a. Was an                     | 24b. Were a           | utopsy findings available       |  |
| Be                         | The la<br>te has<br>age 2   | Completed          |  |   |  |                                |   | autopsy<br>performed            | prior to death?       | completion of cause of          |  |
| ta                         | en: T   | BeC                | 25. Was case referred to medical   |   |  |                                | 26. Place of Death (Cl                                | 1□ Yes 2 2<br>heck only one)    | NO I TO               | ; 2 NO                          |  |
| >                          | nysici<br>nis ce<br>I direc   | ToE                | examiner?  | ospital:                                    | nt 2 ER/Outpatier                        | nt 3 DOA Ott                   | ner: Nursing Home                                     | 5 Residence                     | e 6 ☐Other (Spe       | cify)                           |  |
| 0                          | ng Pt<br>(fter tit<br>Ineral  | .:uo               | 27. Manner of eath 1 Natural 5 □ Pending   | 28a. Date of Inju<br>(Month, Da             | y Year) 28b. Time o                      | f 28c. Inju<br>Wo              | ry at 28d.  | Describe how in                 | njury occurred        |                                 |  |
| <u>sio</u>                 | tendi<br>leath.<br>tor: A<br>the fu   | catl               | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be                          |   |  |                                | Yes 2 □ No  | 10.                             |                       |                                 |  |
| Division of Vital Records, | To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. with Puneral Director. Alther this certificete has been signed by the attending phys completely filled in by the funeral director, page 2 should be deteched for use as the  | Certification:     | 4 Homicide determined  | 28e. Place of Infi<br>building, et          | ury - At home, farm, str<br>c. (Specify) | reet, factory, office          | 281.  | City or Town, Si                |                       | ural Route Number,              |  |
| _                          | spitel  |                    | 29a. Certifier 1 Certifying Phys   | sician: To the best                         | of my knowledge, deat                    | h occurred at the ti           | me, date and place, and                               | due to the causi                | e(s) and manner a     | s stated.                       |  |
|                            | ne Ho<br>n 24 h<br>ne Fu  | Medical            | (Check only 2 Medical Examination one)   | ner: On the basis of<br>and manner sta      | examination and/or in                    | vestigation, in my             | opinion, death occurred a                             | t the time, date                | and place, and due    | e to the cause(s)               |  |
|                            | To the within To the Comp   | Ž                  | 29b. Signature and title of certifier  | K   |  | 29c. Licens                    |   |                                 | Date signed (Mon      | th, Dey, Year)                  |  |
| )                          | _   |                    | Mannion  | -040  |  | 140                            | 03 79 13  | ) /                             | 124/0                 | <i>Y</i>                        |  |
|                            | 5   |                    | 30. Name and address of person who co  | mpleted cause of d                          | 1 1                                      | Print)                         | 059973<br>Cambri                                      | dee                             | Mn                    |                                 |  |
| (2)                        | Sta   | to.                |  | 32. Reg                                     | ramble<br>ar's Signature                 | ST                             | Cambri  | rege                            | , .,                  |                                 |  |
|                            | Registr   |                    | 31. Date filed (Month, Day, Year) JAN 2 8  | 2008  | an A                                     | Andi                           |   |                                 |                       |                                 |  |

State of Maryland / Department of Health and Mental Hygiene 06023 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HULME 28 seraldine 10:30 AM 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7 Eastgate. DR. Apt. 302 WICOMICO CO Date of Birth (Month, Day, Year) 7-23-2 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F NEW YORK Director 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f ehow other traumatic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director SbuRY WICOMICO 10g. Citizen of What Country? 901 atedr. or itama 23a S. by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 NNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Accountin and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BookKeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) srmit. Pages 1 and 2 should be 1 epartment of Health and Mental 1 mortant: If Itam 27 is marked or ANNING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colombia B. Hulme Warwick 6 -claughter Ob. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location -1 ☐ Burial 2 Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 31/08 22. Name and Addrass of Facility

Bennie Smith

FUNERAL Home 21. Signature of Funeral Service Lens W. Isabella S+ SAlisbury, md 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 Marco /Medical Due to (or as a consequence of): Examiner 7721 Sequentially interesting from the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 2 No Day Month Year 4 Pregnant at time of death 5 Other (specify) ed by the 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be del 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has 1 Tes Division of Vital 2 🗆 No To the Hospitel or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) En Outpatient Other: 4 🖸 Nursing Home ome Sesidence 6 Other (Specify)
28d. Sescrib- how injury occurred 1 Yes 2 70 Medical Certification: To 1 Inpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 Natural 5 Pending Injury death. investigation 1 Tyes 2 🗆 No ☐ Accident the within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2045 mo 30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print) 46 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 0 JAN 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 25 **Physician** Year lexand 08 1555 /Medical 4a. Facility Name (Valot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner regional medical Center Nicomico If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2-25-3 (State or Foreign **Funeral** Months Days Hours Min md. Director Usual Residence of Deceden 10a. State 10c\_City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 1 □Yes 2 No omerse **Funeral Director** 10e. Street and Number 10g. Citizen of What Country? S, 12. Was Decedent Ever in U.S. Armed Forces? 1 No 2 No 1 No 2 No 1 No 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Completed by Specify: 3 Widowed 4 Divorced 3/53 2 2/24/55 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Campbell Soup Elementary/Secondary (0-12) College (1-4or 5+) OK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ah ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George A. Whitner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Beulah, Maryland Maryland Veterans 2-4-08 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign vure of Funeral Service License6 2. Name and Address of Fa Bennie Smith Funeral 917 W. I sabella St md 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ELEBRIVASUUL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initiodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examiner for use as the burial-tran and Due to (or as a consequence of) Box 68760, attending physician death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) signed by the a P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2TEN SION 1 ☐ Yes 2 ☐ No 3 Probably 4/2 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of eause of death?
1 ☐ Yes 2 ☐ No has page 2 autopsy certificate 1□ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes ₽ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? Natural (Month, Day Year) 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and addr s of person who completed cau se of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Mont

gistrar's Signature

2008

16b & 19a per F.D. 01/28/2008 Carroll County, will Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death San vary 23 2 V4c. gounty of Death **Physician** Hel phenstine 200 /Medical 4a. Facility Name (If not institution, give street and number)

Novth West Hospital 4b. City, Town, or Location of Death Roudalls + Examiner 1 MOV Q If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sep 29, 1947 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□F Months Days Hours Director 217-46-4932 60 West Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c, City, Town or Location 10b. County "natural", or items 23a or 28a-f show Maryland Reisterstown Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 2 may Injury or other traumatic event, the Merical Examiner must be n once. 21136 106 Sunnydale Way USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ★Yes 2□No Viet
If Yes, Give
Year or Dates: Nam 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ğ Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Computer Environmental Co. Elementary/Secondary (0-12) College (1-4or 5+) Graphics Coordinator Environmental Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phyllis L. Holley James W. Helphenstine ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 106 Sunnydale Way, Reisterstown, MD 21136 Patriodsad Helphenstrine, wife Parricia J. Helphenstine, wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1/30/2008 Owings Mills, MD Garrison Forest Vet. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Pail I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1☐ Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Medical Certification: 1 Natural 2 Accident 5 Pending investigation Injury To the programmer death.

Vithin 24 hours after death.

To the Funeral Director; After the function of the fun 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 10036819 WIL 15 TIVA ame and address of person who completed cause of death (Item 23a) (Type, Print) 5401 TVICLA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **JAN 28** Registrar DHMH 17 Rev 1/2001

16b &

Amended Items

08-00918

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2008

State of Maryland / Department of Health and Mental Hygiene Deirdre Harrison Certificate of Death 1- For State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day February 2, 2008 Physician/ 0602 hrs Examiner 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number Anne Arundel Baltimore Washington Medical Center Glen Burnie 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Director M 2 V F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 No items 23a or 28a-f shov must be notified at once. rector 10g. Citizen of What Country' 喜 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married Yes Specify: 2 No specify: Yes 4 Divorced If Yes. Give Year ≥ 16a. Decedent's Usual Occupation (Give kind of work done Kind of Business/Industr Pages 1 and 2 should be filed within 72 hours a nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natura 32 other traumatic event, the Medical Examir 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) FRIENT CREMATERY 5 Other Specify Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 Approximate Interval neutral o not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Enter he sease or implications that caused vsician Between Onset and Death ledica Hypoglycemia Immediate Cause (Final disease ⊏xaminer Due to (or as a consequence of): or condition resulting in death) Exogenous administration of Insulin for gestational diabetes Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit the Hospital or Attending Physician. The law requires that the death certificate be executed Physician/Medical physician a the burial -X UNPENDED AMENDED 23a,b,Pt.II,27,28a-f per ME g878 4/9/08 amh 23d Date of delivery Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy Day Year Month 23b. Was decedent pregnant in the 3 Ectopic pregnancy 2 🗸 Fetal death Live birth signed by the attending be detached for use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown ⋧ Pneumonia Completed 24b. Were autopsy findings available Records, been prior to completion of cause of autopsy death? performed? certificate has Yes 2 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital uneral director, Be Other<sub>4</sub> Hospital: Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 After this 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death Certification: Yes 2 X No Natura within 24 hours after death.

To the Funeral Director:
completely filled in by the f Pending 5:09a Subject given insulin injection 2/2/08 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7306 Parkway Dr,#103
Hanover,MD(Red Roof Inn) Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide (Specify) Hotel room determined 4 X Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 4, 2008 Jama my me. A, m.D. O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 32, Registrar's Signature 31. Date filed (Month, Day, Year) State FEB Registra

DHMH 17 Rev 1/2001 **OCME 2006** 

OCME

**ORIGINAL** 

peen has certificate

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. To the Hospital o within 24 hours aft To the Funeral Di

Registrar

Attending

0

Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Metastatic Cancer 24a. Was an autopsy 1 Yes 2€ No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ဂ္ 1 Yes 2 No 1 🙀 Inpatient 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: Injury (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License numbe Me

January 24, 2008 D32332

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresu K Gupta, M.D. 9801 Georgia Ave Silver Spring, Maryland

31. Date filed (Month, Day, Year)

2008 JAN 29



State

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 01/22/2008 Joyce P Jackson 8:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's 7. Age (In yrs. last birthday) If Under 1 Year | if Under 24 Hrs. Months Days Hours Min. 5. Social Security Number **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 € F Months Director 578-38-8090 81 02/15/1926 Washington DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show Examiner must be notifled at 1 Yes 2 No Directo 28a-f Prince George's Hillcrest Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 4201 21st P1 Funeral 20748 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. I ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ð Specify: Black 3 Widowed 4 Divorced Year or Dates: other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher City Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 ment of Health and Mental Bernard T Pougue Sarah J Coleman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Mark Walters / Friend 1919 Brewton St., District Heights, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 01/28/2008 Brentwood, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Fort Lincoln Funeral Home 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3401 Bladensburg Rd., Brentwood, MD 20722 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician UBgn /Medical ue to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as attending for use a IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) ed by the a detached f 9☐Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 4 Unknown as been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate ha performe 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 22No Inpatient ٩ 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) Injury 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: All completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation M 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of pertifier 29e-License number 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year) 2008 **JAN 29** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

|  |                 | For State Registrar   | State of Maryland / D  | epartment of Healt<br>Certificate of Dea  |   | al Hygiene<br>Reg. No.                             | 000   | 0 0100   |
|--|-----------------|---|--|---|---|--|---|--|
|  | ician           | Decedent's Name (First, Middle, La SHARON JE)   |  |   | 2. Dat<br>Mo                                    | te of Death onth Day                               | / Year  | 3. Time of Death 9:05AM                            |
| Maria Caracteristics   | edical<br>miner | A. C. sitte Manne (Mana institution of  | re street and number)  | 4b. City, Town, or Locati<br>Germantown   | ion of Death                                    | 4c.  | County of Death                                   |  |
| Funer<br>Direct  |                 | 242-84-6915   | Пи от =  | day) If Under 1 Year If Un<br>Months Days Hou   | order 24 Hrs. 8. Dat<br>ors Min. 06             | te of Birth<br>Donth, Day Year)<br>-14-1954        | 9. Birth<br>Hert                                  | place (State or Foreign<br>ptry)<br>ford Co., N.   |
| e Maryland<br>a-f show<br>iifled at  | ctor            | Usual Residence of Decedent  10a. State  10b. County  Maryland  Montgome                                      | ery Ge   | or Location<br>rmantown   |   |  |   | 10d. Inside City Limits<br>1 to Yes 2 □ No         |
| with the   | Directo         |   | 0: 1   | 10f. Zip Code   |   | 10g. Citi  | zen of What Cou                                   | ntry?  |
| 27.21.5-UU36  J within 72 hours after death with the Maryland jeen. jeen. rthen "natural", or items 23a or 28a-f show the M-dical Ex-miner must be notified at | d by Funeral    | 3 ☐ Widowed 4 ☐ Divorced  | 12. Was Decedent Ever in U.S.<br>Armed Forces?<br>1 □ Yes 2 ★No<br>If Yes, Give<br>Year or Dates:          | 20874  13. Was Decedent of Hispanic If Yes, specify Cuban, Mey  1 □ Yes 2 No Specify Cuban              |   |  |   | ack  |
| 1215-<br>vithin 72<br>sne.<br>than "nat  | Completed       | 15. Decedent's E<br>(Specify only highest gra<br>Elementary/Secondary (0-12)                                  | ducation 16a. I<br>ade completed) (<br>College (1-4or 5+)  | Decedent's Usual Occupation Give kind of work done during life. DO NOT use retired)  Principal          | most of working                                 |  | nd of Business/Ir                                 | ,  |
| 4. O 2 0   | Be              | 17. Father's Name (First, Middle, Last  |  | 18. M   | lother's Name (First,                           | Middle, Maiden                                     | Surname)  | Co School  |
| Maryiand d 2 should be file th and Mental Hy 7 is marked oth traumatic event   | F.              | Caivin Jenkins  | - 0:0 lan  |   | eatrice F                                       |  |   |  |
| s 1 an<br>f Heal<br>ftem 2   |                 | 19a. Informant's Name/Relationship ( Candace Jones/dat 20a. Method of Disposition 1 日 Burial 2 足Cremation 3 日 | ighter 124   | Mailing Address (Street and Nu<br>92 Walnut Cove<br>Disposition (Name of<br>a crematory or other place) |   | ermantow   |   | 874  |
| Baltimore, permit. Pages 1 a Department of Hes Important: If Item any Injury or othe   | once.           | 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice May Hedgma                              | (fy) Riverda   | ale Pk Crematon<br>22. Name and Address of Fa<br>Cedar Hill FH  | acility   |  | rdale, M  |  |
| Physicia   |                 |   | plications that caused the death. Do no<br>one cause on each line.  Metastatic Break                       | of enter the mode of dying, such  |   |  |   | Approximate Interval Between Onset and Death Years |
| / /Medic<br>Examine  | er              | Sequentially list conditions  | b. Due to (or as a consequence of  |   |   |  |   |  |
| icate be executed physician and stee burial-transit  | dical Examiner  | resulting in death) Last  | CDue to (or as a consequence of  | ):  |   |  |   |  |
| BOX teath certife attending for use as   | Physician/Media | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 া No 9 □ Unknown                       | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown | 3 □Ectopic pregnancy<br>5 □ Other (specify)   |   |  | 23d. Date of deliv<br>Month                       | very<br>Day Year                                   |
| F ta fa L  | 2               | a artin other significant conditions  | contributing to death but not resulting in t   | he underlying cause given in P  | art I. 23                                       |  |   | the cause of death?                                |
| The lar<br>ate has   | Completed       |   |  |   |   | a. Was an<br>autopsy<br>performed?<br>] Yes 2 2 No | 24b. Were auto<br>prior to co<br>death?<br>1 ∐Yes | opsy findings available ompletion of cause of      |
| Or VICAL  Physician: 1 r this certificat rral director, p  | a               | 25. Was case referred to medical examiner?  | Hospital:  | Othor   | lace of Death (Chec                             |  |   |  |
| this aldi  |                 |   | 28a. Date of Injury (Month, Day Year)  28b. Ti   | attern of bort 4  |   | Residence (escribe how injur                       |   | fy)  |
| DIVISION C<br>ppital or Attending F<br>ours after death.<br>leral Director: After<br>filled in by the funers   |                 | 3 Suicide 6 Could not b<br>4 Homicide determined  |  | n, street, factory, office  | 28f. Loc<br>Cit                                 | cation (Street an<br>y or Town, State              | d Number or Rur<br>)                              | al Route Number,                                   |
| Hos<br>4 hr<br>ely   | edical          |   | nysiclan: To the best of my knowledge,<br>miner: On the basis of examination and<br>and manner stated.     | death occurred at the time, dat<br>for investigation, in my opinion,                                    | te and place, and due<br>, death occurred at th | e to the cause(s)<br>ne time, date and             | and manner as a<br>d place, and due t             | stated.<br>to the cause(s)                         |
| To the within 2 To the complet   | Me              | 29b. Signature and title of certifier   | lengar l.  | 29c. License numb D 4245  |   |  | te signed (Month,                                 |  |
| P(10)  |                 | 30. Name and address of person who Chitra Rajag pa  | completed cause of death (Item 23a) (T   |   |   |  |   |  |
| 7.4  | State           | 31. Date filed (Month, Day, Year)   | 32. Registrar's Signature  |   | ,,  | 3 9  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** CR Andrew Ohnson 2008 JAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** SA/i S B UR Y

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Wicomico ENINSULA REGIONAL MEdical CTR Social Security Number 3 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 09-10-26 MARYLAND 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f shov must be notified at Parson 1 PYes 2 No Wicomico Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number Ocean City U.S.A Was Decedent Ever in U.S. Arrived Forces?

1 Yes 2 No Il Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) th and Mental Hygiene. 7 is marked other than "natural", or items traumatic event, the Medical Examiner m. 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Anderson Ohnson မ 19b. Mailing Address (Street and Number or Bural-Figure Number, City or Town, State, Zip Code)
11286 SAN DOM TO REGULATION OF A 21837
20 of Disposition (Number of Date) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trauonce. Dwight Johnson -son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Spring Hill Memory Gar. 2-2-08 Hebron, md 21. Sign tyre of Funeral Service Licensee 22. Name and Add ss of Facility. Bennie Smith FUNERAL 917 W. Isabella St Salisbury, md 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diesass or nighty that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ENG

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CARROLL

Simona

**Physician** /Medical Examiner the death certificate be executed burial-transi and Division or Vital Records, P.O. Box 68760 attending physician as the use

Baltimore, Maryland 21215-0036

for Certification:

27. Manner of Death 1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

the

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

within 24 hours a To the Funeral L

1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of (Month, Day Year) Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 Tes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

**JAN 28** 

5 Pending investigation

6 ☐ Could not be

determined

29c. License number DOU65453 29d. Date signed (Month, Day, Year) 6/08

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

2003

Adaku Chimtua Onukegu, M.D. 1500 Forest Glen Road Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year)

State Registrar

Medical



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JAN. 26, 2008 7:29 P. Lialia Kerovic 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Gilcrest Center Towson If Under 1 Year
Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Hours 1□M 2XF 414-77-9780 31, 1943 Montenegro 64 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Maryland Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21045 United States 8728 Hayshed Lane, Apt. 302 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 No Specify 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sahrija Krnic Osman Hadzimuhovic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8728 Hayshed Lane Apt. 302, Columbia, MD 21045 Dervis Kerovic, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition JAN. 27. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National
Memorial Park 4 □ Donation 5 □ Other (Specify) 2008 Laurel, Maryland 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A.
933 Gist Avenue, LL, Silver Spring, MD 20910 21. Signature of Funeral Service Licensee miller M01508 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CArcinomatoss 6 dome Due to (or as a consequence of): pendi if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2

/Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland aritment of Health and Mental Hygiene.

ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at

Saltimore, Maryland 21215-0036

**Physician** 

attending physician

ģ

permit. Page Department o Important: If

as

The law requires that the death certificate be executed

Physician:

this

Hospital or Attending Pl 24 hours after death. Funeral Director: After the

within 24 hours a

To the Funeral C

Division or Vital Records, P.O. Box 68760

Examiner Physician/Medical by Completed Be Certification: To

|                                    |       |                        |        |  |                    |              |       | 1□ Yes    | 2 🔼 No   | 1 ∐ Yes       | 2    |
|------------------------------------|-------|------------------------|--------|--|--------------------|--------------|-------|-----------|----------|---------------|------|
|                                    |       |                        |        |  | 26.                | Place of Dea | th (C | heck only | one)     |               |      |
| spital: 1 🔲 Inpatient              | 2 🗆   | ER/Outpatient          | 3□ DOA |  | Other: 4           | ☐ Nursing H  | ome   | 5 ☐ Res   | idence 6 | 6 Other (Spec | ity) |
| 28a. Date of Injury<br>(Month, Day | rear) | 28b. Time of<br>Injury |        |  | Injury at<br>Work? |              |       |           |          | y occurred    |      |

| 27. Manner of Death<br>1 ☑ Natural<br>2 ☐ Accident | 5 Pending investigation   | 28a. Date of Injury<br>(Month, Day Year)             | 28b. Time of<br>Injury | M        | 28c. Injury at<br>Work?<br>1 ☐ Yes | 2[ |
|--|---------------------------|--|------------------------|----------|------------------------------------|----|
| 3 ☐ Suicide<br>4 ☐ Homicide                        | 6 Could not be determined | 28e. Place of injury - At he building, etc. (Special | ome, farm, stre        | et, fact | ory, office                        |    |

Ho

| ı |      |                        |                          |                |          |          |       |
|---|------|------------------------|--------------------------|----------------|----------|----------|-------|
|   | 28f. | Location<br>City or To | (Street ar<br>own, State | nd Numbe<br>e) | r or Run | al Route | Numbe |

| Lou. | (Check only one) |                   | Examiner: |      | of examination<br>tated. |   |
|------|------------------|-------------------|-----------|------|--------------------------|---|
| 29b. | Signature and    | title of certifie | r         | 1.17 |                          | ^ |

25. Was case referred to medical examiner?

1 Yes 2 No

29a, Certifier

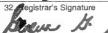
| 1 Certifying Phys  | ician: To the best of my knowledge, death occu                         | urred at the time, date and place | , and due to th   | e cause(s) and manner as   | stated.      |
|--------------------|--|-----------------------------------|-------------------|----------------------------|--------------|
| 2 ☐ Medical Examir | ner: On the basis of examination and/or investig<br>and manner stated. | ation, in my opinion, death occu  | urred at the time | e, date and place, and due | to the cause |
| title of contifier |  | 20c License number                |                   | 20d Date signed (Month     | Day Year     |

| Signature and title of certifier  Multiple  Mu | y Nila           | · m               | ۵                        | 29c, License number  j) 25 20 3 |        | -   | gned (Month, Day, | Ye |
|--|------------------|-------------------|--------------------------|---------------------------------|--------|-----|-------------------|----|
| Name and address of person who   | Completed causes | death (Item 23a   | a) (Type, Print)<br>N. ( | harles St.                      | feelte | ind | 2170              | ۴  |
| Date filed (Month, Day, Year)  JAN 2 8 2   | 008 32 egis      | strar's Signature | Spare                    | E)                              |        |     |                   |    |
|  |                  |                   |                          |                                 |        |     |                   |    |

|    | State   |
|----|---------|
| Re | gistrar |

Medical

31. Date filed (Month, Day, Year) **JAN 28** 2008





Amend #25 per ME G882 8/29/08 TT

|                             |   |                | Amend #25 pe<br>1 - State<br>Registrar  | r ME G88<br>State o                          | 12 '87297<br>f Marylan                           | d / Depa                                   | artmen<br>rtificat          | t of H                  | lealth a                     |            |  | -                            | 008   | Per stand                         | 033       |
|-----------------------------|---|----------------|---|--|--|--|-----------------------------|-------------------------|------------------------------|------------|--|------------------------------|---|-----------------------------------|-----------|
|                             |   |                | Decedent's Name (First, Middle, L.  | ast)   |  |  | -                           |                         |                              | Ī          | 2. Date of De                          |                              |   | 3. Time of                        | Death     |
|                             | Physici   |                | Lawrenc   | е Ј. к                                       | Cuhaneck   | 2  |                             |                         |                              |            | Month<br>Januar                        | y 28,                        | 2008  | 10:35                             | , ам      |
|                             | /Medio<br>Examir  |                | 4a. Facility Name (If not institution, g  | ive street and nui                           | mber)  |  | 4b. City,                   | Town, or                | Location of                  | Death      |  | 4c. Coun                     | ty of Death                                   | L                                 |           |
|                             | LAdillii  | ici            | Harford Memor   | ial Hosp                                     | oital  |  |                             | Ha                      | vre de                       | e Gra      | ace                                    |                              | Harfo   | rd                                |           |
|                             | Funeral<br>Director   |                | 5. Social Security Number 6. 134-05-1060  | Sex<br>1⊈M 2□F                               | 7. Age (In yrs.<br>96                            | last birthday)<br>Yrs.                     | If Under<br>Months          | 1 Year<br>Days          | If Under 2<br>Hours          | Min.       | 8. Date of Bir<br>(Month, Da<br>Oct. 1 | th Year)<br>1,1915           | 9. Birthp<br>Cour<br>Ne                       | iace (State or<br>itry)<br>W York | Foreign   |
| _                           | 9   |                | Usual Residence of Decedent   |  | T40 01   |  |                             |                         |                              |            |  |                              |   |                                   | 4.5       |
|                             | arylar<br>phow  | <u></u>        | 10a. State 10b. County  |  | Tuc. Cit   | y, Town or Lo                              | ocation                     |                         |                              |            |  |                              | 1   | 0d. Inside Cit<br>1 XYes          |           |
|                             | 8a-1  | octo           | Maryland  |  |  |  |                             |                         | timor                        | e          |  |                              |   |                                   |           |
|                             | death with the Maryland<br>me 23a or 28a-f ehow<br>count be coulfind at   | Directo        | 10e. Street and Number<br>1313 Marshall St  |  |  |  | 10f. Zip                    |                         | 230                          |            |  | 10g. Cilizen o               | U.S.A   | •                                 |           |
|                             | • 23  | Funeral        |   |  | edent Ever in U                                  | C 42                                       | Was Dass                    |                         |                              | i=2 /Cn=   | arfu Van er Ne                         |                              | ace - Americ                                  |                                   |           |
|                             | er de   | ij.            | <ul><li>11. Marital Status</li><li>1   Never Married 2   Married</li></ul>  | Armed Fo                                     | rces?  | .5. 13.                                    | If Yes, spec                | ent of H                | in, Mexican,                 | Puerto l   | ecify Yes or No<br>Rican, etc.)        | B                            | ack, White,                                   |                                   |           |
| 38                          | irs af  | by F           | 3 ☐ Widowed 4 ☐ Divorced  | If Yes Gr                                    | ve 1944  | 1-46                                       | 1 🗆 Yes                     | 2 <b>☑</b> No           | Specify:                     |            |  | Spec                         | eify: W                                       | hite                              |           |
| 5-0036                      | d within 72 hours after death with the Marylar sjene. Then maturel, or lieme 23e or 28e-f ehow then maturel or market in the motified at  | ted            | 15. Decedent's  | Education                                    |  | 16a. Dece                                  | dent's Usua                 | al Occupi               | ation                        |            |  | 16b. Kind of                 | Business/In                                   | dustry                            |           |
| 275                         | hin 7.  | ple            | (Specify only highest g<br>Elementary/Secondary (0-12)  | College (                                    | 1-4or 5+)  | (Give                                      | DO NOT u                    | rk done d<br>se retired | during most<br>()            | of workii  | ng                                     | Bethle                       | ehem S  | teel                              |           |
| 25                          | d with  | Completed      | unknown   | unkno  |  |  | Labo                        | orer                    |                              |            |  | Balti                        | more,   | Maryla                            | nd        |
|                             | ould be filed within Mental Hygiene.  Sarked other then satic event, Item   | Be             | 17. Father's Name (First, Middle, Las   | st)  |  |  |                             |                         | 18. Mother                   | r's Name   | (First, Middle                         | , Maiden Sum                 | ame)  |                                   |           |
| <u>a</u>                    | Ments<br>Ments<br>arked   | 10             | Michael   | Kuhaneck                                     | 3  |  |                             |                         |                              |            | Ethel                                  | Kemees                       |   |                                   |           |
| /28 $/38$ /kimore, Maryland | 2 should be filed within and Mental Hygiene.  Is marked other then surnatic event, ILA M  |                | 19a. Informant's Name/Relationship  |  |  | 1  | •                           |                         |                              |            |  | er, City or Tow              |   |                                   | 0-005     |
| 7≥                          | end<br>ealth<br>m 27  |                | Aimee Saylor Decede   | nt Affairs                                   |  |  |                             |                         | althcar                      |            |  | g. 361,                      |   |                                   | 2 2190    |
| $\infty$                    | of H  |                | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3   | Removal from                                 | State Cros                                       | Place of Dispo<br>cemetery, crei<br>wnsvil | matory or o                 | ne of<br>ther plac      | (e)                          |            | ate                                    | 20c. Location                |   |                                   |           |
| SIE                         | Pag<br>ment<br>ant:<br>ury c  |                | 4 □ Donation 5 □ Other (Spec  |  | CFO  | Cem  | etery                       | tera                    | ns ;                         | 02/0       | 1/08                                   | Crowns                       | ville   | , Mary                            | land      |
| O                           | permit. Pages 1 end 2 should be filed. Department of Health and Mental Hyginiportant: If Item 27 le marked othe eny injury or other treumatic event, ance.                          |                | 21. Signature of Funeral Service Lic  | ensee  | CAND   | . C.L                                      | ee A.                       | Pat                     |                              | n &        |  | neral H<br>03-0766           |   | P.A.                              |           |
| ~                           | Marie Sale  |                | 23a. Part1. Enter the disease, or co shock, or heart failure. List on   | mplications that o                           | aused the deat                                   | h. Do not en                               | ter the mod                 | le of dyin              | g, such as                   | cardiac o  | or respiratory a                       | rrest,                       |   | Approximate<br>Interval Bety      | ween      |
| d O                         | Physician   |                | Immediate Cause (Final disease or condition   | (  | 70-5   | · C-                                       | . Co A-                     | A                       | th m                         | 5.         |  | /                            |   | Onset and [                       | )eath     |
| 15                          | /Medical  |                | resulting in death)   | a. Due to                                    | (or as a conseq                                  | uence of):                                 | NEW.                        | 130                     | 1.0                          | ~ 0x       | 4                                      | 11                           |   |                                   |           |
| 25                          | Examiner  |                | Sequentially list conditions  | b  |  |  |                             |                         |                              |            | ///                                    |                              |   |                                   |           |
|                             | ₽ #   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to                                       | (or as a conseq                                  | uanca of).                                 |                             |                         |                              |            | ROVED & COR                            | EXAMINE                      |   |                                   |           |
| (1)                         | ecute<br>and<br>trans   | Kam            | that initiated events resulting in death) Last  | C. Due to                                    | (or as a conseq                                  | wanca of):                                 |                             |                         | -0                           | - 6        | E ESIC                                 | 34                           |   |                                   |           |
| 760.                        | ate be executed<br>sysician and<br>he burial-transit  | calE           |   | Due to                                       | (O) 83 8 CO1130Q                                 | 301109 01).                                |                             |                         |                              | IN APP     | ROVED                                  |                              |   |                                   |           |
| ή)(<br>687                  | phys<br>the   |                |   | d  |  |  |                             |                         | TERTIFICA                    | 214        |  |                              |   |                                   |           |
|                             |   | Physician/Med  | IF FEMALE:  | 23c. If ves. ou                              | tcome of pregna                                  | ancv                                       |                             |                         |                              | 1          |  |                              | Date of delive                                | 20/                               |           |
| Dox Box                     | wrequires that the death cer<br>been signed by the attendir<br>should be detached for use   | clar           | 23b. Was decedent pregnant in the past 12 months?   | 1☐Live t                                     | oirth 2 ☐ Feta<br>nant at time of d              | I death 3                                  | □Ectopic po<br>□ Other (sp  |                         |                              |            |  |                              | Month   | ,                                 | Year      |
| ≥ 0                         | the d<br>by the   | Jysi           | 1 Yes 2 No<br>9 Unknown   | 9□ Unkn                                      |  |  |                             | ,, _                    |                              |            |  |                              |   |                                   |           |
| 29                          | that<br>hed by<br>deta  | by Pt          | Part II. Other significant conditions   | contributing to d                            | eath but not res                                 | ulting in the u                            | ınderlying c                | ause giv                | en in Part I.                |            | 23e. Did                               | tobacco use co               | ontribute to t                                | ne cause of d                     | eath?     |
|                             | equires<br>sen sign<br>could be   |                | GI Ble  | عط   |  |  |                             |                         |                              |            | 1 🗆                                    | Yes 2 No                     | 3 🗆 Prot                                      | ably 4 ⊡⊀                         | nknown    |
| K<br>ecor                   | s bee   | Completed      |   |  |  |  |                             |                         |                              |            | 24a. Was                               |                              | . Were auto                                   | psy findings                      | available |
| Re                          | icien: The lav<br>certificate has<br>rector, page 2   | Ë              |   |  |  |  |                             |                         |                              |            |  | ormed?                       | prior to co<br>death?<br>1 \( \sum \text{Yes} | mpletion of c                     | ause of   |
| ta 🔀                        | en: ]   | 0              | 25. Was case referred to medical  |  |  |  |                             | -                       | 26 Place                     | of Death   | 1 ☐ Yes                                | -                            | 1 1 1 1 1 1 1 1                               | 26110                             |           |
| <u> </u>                    | Physicien:<br>this certific<br>ral director,  | 0 8            | examiner?<br>1XX Yes <del>2⊠1\0</del>   | Hospital: 1                                  | Inpatient 2                                      | ER/Outpaties                               | nt 3 🗆 DC                   | Oth                     |                              |            |  | idence 6 🗆 C                 | ther (Specia                                  | v)                                |           |
| ₹ 5                         | g Phys<br>er this<br>neral di   | n: T           | 27. Manner of Death   | 28a. Date                                    | of Injury<br>th, Day Year)                       | 28b. Time o                                | -                           | 8c. Injun               | v at                         |            |  | how injury occ               |   | ,                                 |           |
| 2<br>Roles                  | Attending I<br>r death.<br>octor: After<br>by the funer   | atio           | 1 Natural 5 ☐ Pending 2 ☐ Accident investigat   |  | , 22) . 32.7                                     | .,,,,,                                     | М                           |                         | Yes 2 1                      | No         |  |                              |   |                                   |           |
| vis v                       | er de<br>recto  | Certification: | 3 ☐ Suicide 6 ☐ Could not determine   | ed 289. Place                                | of Injury - At he                                |  | reet, factor                | , office                | Here House                   |            | 28f. Location (<br>City or To          | Street and Nui<br>wn, State) | mber or Rura                                  | al Route Num                      | ber,      |
| 29                          | rs after or rs after or rs after or ra after or ra blr of in ed in  | Ce             |   |  |  |  |                             |                         |                              |            |  |                              |   |                                   |           |
| $\checkmark$                | To the Hospital or Attending Physicien: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Medical        | 29a. Certifier 1 Certifying I (Check only one) 1 Medical Ex   | Physician: To the<br>aminer: On the band man | best of my kno<br>asis of examina<br>ner stated. | owledge, deat<br>ation and/or in           | th occurred<br>evestigation | at the tin<br>, in my o | ne, date and<br>pinion, deat | d place, a | and due to the<br>ed at the time,      | date and plac                | manner as s<br>e, and due t                   | tated.<br>the cause(s             | )         |
|                             | To the To the Comp  | ž              | 29b. Signature and title of certifier   | , _  | \  |  |                             |                         | e number                     |            |  | 29d. Date sig                |   |                                   |           |
|                             |   |                | Jay 1/2   | e MI   | ,  |  |                             | DE                      | 590                          | 5          | -                                      | 11                           | 28/   | 2008                              |           |
|                             | IVA   |                | 30. Name and address of person wh   | o completed caus                             | c 11   | m 23a) (Type,                              | Print)<br>AVE               | HA                      | ivre                         | de         | GRACE                                  | 1]<br>Mo.                    | 210   | 78                                |           |
|                             | Sta   |                | 31. Date filed (Month, Day, Year)   | 32. F  | Registrar's Signa                                | ature                                      |                             |                         |                              |            |  |                              |   |                                   |           |
|                             | Registi   | ar             | JULY O O  | _000   | MURI J   | C. JES                                     | ATTE                        |                         |                              |            |  |                              |   |                                   |           |

|  |                  |   | Please  | Type or Prin                                     |                            |                       |   |  |                                 |                              | egible.                       |  |
|--|------------------|---|---|--|----------------------------|-----------------------|---|--|---------------------------------|------------------------------|-------------------------------|--|
|  |                  | For<br>State  |   | State of Ma                                      | arylanc                    |                       | artment of H<br><i>rtificate of L</i>           |  | •                               | •                            | 200                           | o ni.noi   |
| · ·  |                  | Registrar  1. Decedent's Nam  | ne (First, Middle, La                         | as <i>t)</i>                                     |                            | Ce                    | Tillicate of t                                  | Dealli                                     | 2. Date of De                   | Reg. No.                     | <u> </u>                      | 3. Time of Death                                 |
| Physicia   |                  |   |   | Lynch, Jr  | •                          |                       |   |  | Month                           | 29 <sup>pay</sup>            | 20ඊ්්                         | 9:30 A M   |
| /Medic<br>Examin   |                  | 4a. Facility Name (   | 'If not institution, gi                       | ve street and number)                            |                            |                       |   | Location of Death                          |                                 |                              | ounty of Deat                 |  |
|  |                  | 104 Es  | ham Ave.                                      | Sex 7. Aq  | a (la usa la               | o t hirthday)         | Berlir If Under 1 Year                          | If Under 24 Hrs.                           | 8. Date of Bir                  |                              | rceste                        |  |
| Funeral<br>Director  |                  | 214-36-6  |   | 1 XX M 2 □ F                                     | e (In <i>yrs. la</i><br>68 | Yrs.                  | Months Days                                     | Hours Min.                                 | (Month, Da                      | ıy, Year)                    | 9. BIII<br>Co                 | hplace (State or Foreign<br>untry)<br>MD         |
| Willer Same  |                  | Usual Residence o   | of Decedent                                   |  |                            |                       |   |  | 1/2//1                          | 310                          |                               |  |
| arylar<br>show   | 'n               | 10a. State  | 10b. County                                   | L  | , ,                        | Town or Lo            | ocation   |  |                                 |                              |                               | 10d. Inside City Limits 1 ☐ Yes 2 🕱 No           |
| the M<br>28a-f<br>notifie  | Funeral Director | MD<br>10e. Street and Nu  | Worces  | ter  | Bei                        | rlin                  | 10f. Zip Code                                   |  |                                 | 10g. Citize                  | en of What Co                 | untry?   |
| h with<br>23a or<br>st be  | al Di            | 104 Esha  | m Ave.  |  |                            |                       | 218   | 811  |                                 | US                           | SA                            |  |
| r deat<br>ems  | ner              | 11. Marital Status  |   | 12. Was Decedent  <br>Armed Forces?              |                            | 13.                   | Was Decedent of Hi<br>If Yes, specify Cuba      | ispanic Origin? (Sp<br>an, Mexican, Puerto | ecify Yes or No<br>Rican, etc.) | )- 14                        | 1. Race - Ame<br>Black, White |  |
| s afte   | by Fu            | 1 ☐ Never Man<br>3 🕅 Widowed  | ried 2 Married                                | 1 ☐ Yes 2 ☑ If<br>If Yes, Give<br>Year or Dates: | No                         |                       | 1 ☐ Yes 2 🔀 No                                  | Specify:                                   |                                 |                              | Specify: Wh                   | ite  |
| 72 hours after death with the Marylar 72 hours after death with the Marylar "natural", or items 23a or 28a-f show adical Examiner must be notified at  |                  |   | 15. Decedent's E                              | ducation   |                            | 16a. Dece             | dent's Usual Occup                              | ation                                      |                                 | 16b. Kind                    | d of Business/                |  |
| thin 7<br>thin 7<br>ie.  | Completed        | Elementary/Seco   | ondary (0-12)                                 | College (1-4or 5                                 | i+)                        |                       | kind of work done of<br>DO NOT use retired      | auring most of work<br>1)                  | ang                             |                              | _                             |  |
| led wi   |                  | 17 Eathar's Nama  | (First, Middle, Las                           | 1  |                            | Mana                  | ager  | 18. Mother's Name                          | e /Firet Middle                 |                              | otel                          |  |
| d be fi  | o Be             |   | H. Lyncl                                      | •  |                            |                       |   | Mary Lo                                    | ,,                              | ,                            | amamey                        |  |
| 2 should be filed within 72 hours after death with the Maryland and Memberland Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at   | 욘                |   | lame/Relationship                             |  |                            | 19b. Maili            | ng Address (Street                              |  |                                 |                              | Town, State, 2                | Zip Code)  |
| and 2<br>ealth a<br>m 27 is  |                  | Thomas  | Lynch / I                                     | orother  |                            |                       | West St.  |  |                                 |                              |                               |  |
| permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Menlal Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical.  |                  | 20a. Method of Dis<br>1 XBurial 2                                   |   | ☐Removal from State                              | - 1                        |                       | osition (Name of<br>matory or other place       |  | Date                            |                              | ation - City or               |  |
| it. Pa<br>rtmen<br>rtant:<br>njury   |                  |   | 5 Other (Spec                                 |  | Bucl                       |                       | am Cemeter  2. Name and Addres                  |  | 2008<br>he Burt                 |                              | lin, MD                       |  |
| perm<br>Depa<br>Impo<br>any i  |                  | 21. Signature bur   | uneral Service Lice                           | Bu Lan   |                            |                       |   | iam St.,                                   |                                 |                              |                               | поше   |
| 1 - S (M)  |                  | 23a, Part1. Enter   | the disease, or cor<br>art failure. List only | nplications that are ed                          | the death.                 | Do not en             |   |  |                                 |                              |                               | Approximate<br>Interval Between                  |
| Physician  | 2 5              | Immediate Cause   | (Final  | hru  | 216.                       | 6/29                  | Twetw   | c ///1                                     | Mouny                           | 1/1                          | 5 88/4                        | Onset and Death                                  |
| /Medical<br>Examiner   |                  | resulting in death)   |   | Due to (or as                                    | a consequ                  | ence of):             | 1   |  | 1                               |                              |                               |  |
| Examine  | -i-              | Sequentially list co<br>if any, leading to in<br>cause. Enter Under | onditions,                                    | b<br>Due to (or as                               | a consequ                  | ence of):             |   |  |                                 |                              |                               |  |
| executed<br>in and<br>ial-transit  | Examiner         | cause. Enter Und<br>Cause (Disease of<br>that initiated event       | r injury                                      | C  |                            | ,                     |   |  |                                 |                              |                               |  |
| e executed<br>an and<br>urial-transit  | Еха              | resulting in death)   | Last  | Due to (or as                                    | a consequ                  | ence of):             |   |  |                                 |                              |                               |  |
| eath certificate be attending physici for use as the bu  | dica             |   |   | d  |                            |                       |   |  |                                 |                              |                               |  |
| certifii<br>nding p  | Physician/Medica | IF FEMALE:  | nt prognant                                   | 23c. If yes, outcome                             |                            |                       |   |  |                                 | 23                           | 3d. Date of de                | iverv  |
| death<br>e atter<br>d for u  | iciar            | 23b. Was deceder<br>in the past 12<br>1 \(\superscript{Yes}\) 2     | 2 months?                                     | 1 ☐Live birth<br>4☐Pregnant at                   |                            |                       | ⊒Ectopic pregnancy<br>⊒ Other (s <i>pecify)</i> | /  |                                 |                              | Month                         | Day Year   |
| at the by the tacher   | hys              | 9 🗆 Unknowi   | n   | 9□Unknown  |                            |                       |   |  |                                 |                              |                               |  |
| w requires that the debeen signed by the should be defached  | þ                | Part II. Other sign   | ificant conditions                            | contributing to death b                          | ut not resul               | ting in the u         | inderlying cause giv                            | en in Part I.                              |                                 | tobacco us<br>Yes 2□         | 20                            | o the cause of death?  Tobably 4 □Unknown        |
| requi  | eted             |   |   |  |                            |                       |   |  |                                 |                              | 7                             |  |
| he law<br>e has b  | Completed        | _   |   |  |                            |                       |   |  | 24a. Was<br>auto<br>perf        | psy<br>ormed?                | prior to death?               | utopsy findings available completion of cause of |
| sician: The<br>certificate I   |                  | 25. Was case refe   | erred to medical                              |  |                            |                       | ·   | 26. Place of Deat                          |                                 | 2 <b>2 0</b> 0 on <i>e</i> ) | 1 □Yes                        | 2 □ No   |
| ding Physician: The n. After this certificate he funeral director, page  | To Be            | examiner?<br>1 ☐ Yes 2  | [ No  | Hospital: 1 ☐ Inpatie                            | ent 2 🗆 E                  | R/Outpatie            | nt 3□ DOA Oth                                   |  | 11                              |                              | □Other (Spe                   | cify)  |
| ing Pt   | 1                | 27. Manner of Dea<br>1 Natural                                      | 5 Pending                                     | 28a. Date of Inju<br>(Month, Da                  |                            | 28b. Time o<br>Injury | Wor   |  | 28d. Describe                   | how injury                   | occurred                      |  |
| ttend<br>death.<br>ctor: /   | icati            | 2 ☐ Accident<br>3 ☐ Suicide   | investigation 6 ☐ Could not                   | oe 290 Place of init                             | urv - At hor               | ne. farm. st          | M 1 ☐   | Yes 2□No                                   | 28f. Location                   | Street and                   | Number or R                   | ural Route Number,                               |
| affer affer I Direct of in by  | Certification:   | 4 ☐ Homicide  | determine                                     | building, et                                     | c. (Specify                | ),,                   | · · · · · · · · · · · · · · · · · · ·           |  |                                 | wn, State)                   |                               |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Luneral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burner. |                  | 29a. Certifier<br>(Check only                                       |   | hysician: To the best                            |                            |                       |   |  |                                 |                              |                               |  |
| thin 24<br>thin 24<br>the F  | Medical          | one) 29b. Signature and   |   | and manner sta                                   |                            |                       | 29c. Licens                                     |  | Т                               |                              | signed (Mon                   |  |
| 7 will will 00   |                  | 29b. Signature and  |   | .04  | Ω.                         |                       | 0/  | 4585                                       |                                 | 1/                           | 796                           | 38   |
|  |                  | 30. Name and add  | dress of person who                           | completed cause of d                             | lean (tem                  | 23a) (Type,           | Priht) lu                                       | , 50                                       | ~                               | , 1,1                        | 010                           | 21011  |
| D7/ 10   |                  | Anth  | in /  | evera 1  | 1+                         | 5) /                  | Teally L  | ay 1/1                                     | 07 1)                           | erlin                        | [ND                           | CUL  |
| Sta<br>Registr   |                  | 1. Date filed (Mo   |   | 32. Registr                                      | ars Signat                 | ure .                 | 1 .   | 1 *  |                                 |                              |                               | `  |
| negisti  | u I              |   | JAN 3 0                                       | 2008   | au .                       | J.                    | (part)  |  |                                 |                              |                               |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** lable 2008 04:20 M POnard 23 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hantic Ber If Under 1 Ye Worcest Genera If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 20 F Months Days Hours Min. 245-42-0912 75 Yrs. Director 7/29/1932 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 2 should be tiled within 72 moure—and Mental Hygiene.
Is marked other then "neturel", or Items 23e or 28e-f show "is marked other then "neturel", or Items 23e or 28e-f show "is marked other than "neturel", or Items 25e or 28e-f show "is marked other transfer or 28e-f show "is marked or 28e-f show "is marked other transfer or 28e-f show "is marked or 28e-f show "is mark 10d. Inside City Limits 1 ☐Yes 2 ☐ No Funeral Director Worecester Jer 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Berlin LSF Koad 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No ģ Specify: lac 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) newer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknow trene a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 is Department of Heetth ar Important: If Item 27 Is any injury or other trau ial Kood DeaHawk MD Leonard trusband Derlin Place of Disposition (Name of corpetary, crematory or other place) Baltimore, 20a. Method of Disposition 20b. Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Berlin toul unc 4 □ Donation 5 □ Other (Specify) 3008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W. Isabella St 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such is cardiac or respiratory arrespiratory arrespiratory on each line. oal isbury 10216 am oroximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physicien and d be detached for use as the burial-transit Due to (or as a consequence of): 68760, Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 A No 9 ☐ Unknown Day Year 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ icete hes been siç , page 2 should b Completed 1 X Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 LI No certificete Vital 25. Was case referred to medical examiner? funeral director 26. Place of Death Check only one) setter death.
I Director: After this cod in by the funeral dire Hospital: 2 No 1 Tes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient of 2 ER/Outpatient 3 DOA 27. Manner of Death Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No M 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours et 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) le signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 1/2001

State

Registrar

30 Name and address of person wto co

9 2008

31 Date filed (Month

104:20

80

DOD: 1/23/

32

1/29

DB:

412

**55**#

Leonard, Maine

se of death (Ifem 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Month Year **Physician** MICHAEL WELDON MOORE SR. 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomic JUSSING 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex 1 X M 2 ☐ F **Funeral** Days Min. Months Hours 21, FEB. 1961 PENNSYLVANIA 211-54-4649 46 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County ns 23a or 28a-f shormust be notified at 1X Yes 2 No Director WORCESTER OCEAN CITY MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 603 GULF STREAM DRIVE 21842 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or Items 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 □ Never Married 2 M Married 1 ☐ Yes 2 X No WHITE Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED CONTRACTOR 12 CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be THOMAS MOORE SR. ANNA MEEKINS ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 60 603 GULF STREAM DRIVE, OCEAN CITY, MD 21842 JOANN M. MOORE/WIFE permit. Pages 1 and Department of Healt Important; If Item 2 any injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) CREMATORY OF DELMARVA 1/29/08 DELMAR, DELAWARE 21. Sign ure Juneral Service Lice 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) R. **Physician** azi /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Clus. (Discussion of July) that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and ts the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 7 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 10 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 1 ☐ Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident within 24 hours after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. lisburg Dilliam sobins, M.D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O Physician Day Year 7:25P M WAY /Medical 2008 4b. City, Town, or Location of Death acility Name (If not institution, give street and number Examiner 4c. County of Death Regional medical Cem NICOMICO 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** JEM 2□F Days Hours Months Min. Director MAYV Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1. Yes 2 No Director E CCOMACK 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11. Marital Status 30569 Funeral 5. 12. Was Decedent Ever in U.S. Armed Forces? 1 25 res 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 Married Maryland 21215-0036 Specify: Whit 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Gper grapuate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be MCFOTD 50 WILLIAM ا ج شرية و 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jean 70 Church 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1514ND 30/08 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
FOR FUNETRI HOME LAWKFOTD HGY 1045 ames em PerANCEVILLA  $\mathcal{M}$ 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, hock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2: autopsy performed? Yes 2**X** No 1 Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 1 🔲 Inpatient 2 X ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

-126 P.O. Records, Vital

Division or

24 hours after death Funeral Director: filled in by within 24 hor To the Fune completely f 2

29b. Signature and title of certi-

29a. Certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who e of death (Item 23a) (Type, Print)

Simona ·CN9 255011

2008

State

Medical

JAN 30 Registrar

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 6 per fb 9876 2-12-08 vt State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 **Physician** 03 Myrtle 1045 Maxine Moyers /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WMHS Braddock Campus Cumber land Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4-23-1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** t Virginia Days Hours Min. 1 ☐ M 2 X F West **Director** 213-22-3723 Usual Residence of Decedent 84 10c. City, Town or Location the Maryland 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Frostburg MD Allegany Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with it Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 and hijury or other traumatic event, the Medical Examiner must be no once. 21532 United States by Funeral 16709 Loartown Rd SW 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amanda Uphold Pullem John Pullem ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21532 16709 Loartown Rd SW Frostburg, Debra Loar 20a. Method of Disposition daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Moyers Family Cem 2-9-2008 Franklin, WV 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Sowers Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Immediate Ceuse (Final disease or condition resulting in death) **Physician** HEART FAILURE CONGESTIVE about syrs /Medical Due to (or as a consequence of) **Examiner** CORDNARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exami burial-trar Due to (or as a consequence of) Box 68760 physician Physician/Medical attending ph for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC OBSTRUCTURE LUNG DUEMER 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b rector, page 2 sl 24a. Was an autopsy performed? res 24 No 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury s after dea. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Plece of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours af **To the Funeral D** completely filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY 1 26907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 Bishop waish Road, Cumberland, MD 21502 Harjit Sidhu m.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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|-----------|------------|--------------|--------|-----------|---------|--------|------|
| State of  | Maryland / | Department   | of He  | ealth and | Mental  | Hygier | ne   |

|                     |   |                  | 1 - For<br>State<br>Registrar  |  | State of Ma   | iryiano        |                                |                         |                             | Death   |   | giene<br>Reg. No                     |   | 10   | o t.                                 | 03                 |
|---------------------|---|------------------|--|--|---|----------------|--------------------------------|-------------------------|-----------------------------|---|---|--------------------------------------|---|--|--------------------------------------|--------------------|
| 9                   | Physici   |                  | 1. Decedent's Name (Fir.   | st, Middle, Last                               | Norris  |                |                                |                         |                             |   | 2. Date of De<br>Month<br><b>January</b>        |                                      | , 2008                                    |  | ne of D                              | P M                |
|                     | /Medio  |                  | 4a. Facility Name (If not in 516 68th S  |  | street and number)  |                |                                |                         |                             | Location of Deat                                    |   | 4c.                                  | County of De                              | ath  |                                      |                    |
|                     | Funeral<br>Director   |                  | 5. Social Security Number 217–32–3030  | er 6. Se                                       |   | e (In yrs. las | st birthday)<br>Yrs.           |                         | er 1 Year                   | If Under 24 Hrs<br>Hours Min.                       |   | th                                   | 9. B                                      | irthplace (S<br>Country)<br>shing                  | tate or I                            | -                  |
| 1                   | show<br>ad at   | or               |  | edent<br>County                                |   |                | Town or Lo                     |                         |                             |   |   |                                      |   | 10d. Insi  | de City<br>Yes 2                     |                    |
| 46700               | a or 28a-f<br>t be notifie  | Funeral Director | 10e. Street and Number 516 68th S  |  | eorge's   | Seat           | Plea                           | 10f. Z                  | p Code                      |   |   |                                      | izen of What (                            | Country?   |                                      |                    |
| d 21215-0036        | and of Mental Hygiene. marked other than "natural"; or items 23a or 28a-f show imatic event, the Medical Examiner must be notified at |                  | 11. Marital Status 1   | 1  | 12. Was Decedent E<br>Armed Forces?<br>1 ☑ Yes 2 ☐ N<br>If Yes, Give<br>Year or Dates:  |                |                                | Was Dec<br>If Yes, sp   | edent of H<br>ecify Cuba    | ispanic Origin? (S<br>In, Mexican, Puer<br>Specify: | Specify Yes or No<br>to Rican, etc.)            |                                      | 14. Race - An<br>Black, Wh<br>Specify: Wh | nerican India<br>nite, etc.                        | an,                                  |                    |
| Maryland 21215-0036 | ene.<br>than "natu<br>he Medical  | Completed by     | 15. I<br>(Specify or<br>Elementary/Secondary   | Decedent's Edu<br>nly highest grad<br>y (0-12) | ucation<br>de completed)<br>College (1-4or 5-<br>+2   | +)             | 16a. Deced<br>(Give<br>life. I | kind of w               | ork done d<br>use retired   | during most of wo                                   | rking   |                                      | ind of Busines                            | s/Industry   |                                      |                    |
| land 2              | e de la   | To Be Co         | 17. Father's Name (First   | , Middle, Last)                                |   | l .            |                                |                         |                             |   | me (First, Middle,<br>K. Miles                  | Maiden                               |   |  |                                      |                    |
| Maryla              | E S S   | -                | 19a. Informant's Name/F  |  | ,   |                |                                | _                       |                             | and Number or R                                     |   | -                                    |   |  |                                      |                    |
| re,                 |   |                  | Steven J. N  20a. Method of Disposition  1 Burial 2 X Cre 4 Donation 5 D   | on<br>emation 3 ∐f                             | Removal from State  | 20b. Plac      | ce of Dispo<br>netery, crer    | sition (Na<br>natory or | ame of<br>other plac        | et Sea<br>e)<br>atory 1-                            | Date  | 20c. Lo                              | ocation - City                            | or Town, Sta                                       | te                                   |                    |
| Baltii              | Department of mage and injury or once.  |                  | 21. Signature of Funeral   |  |   |                | 22                             | 2. Name a               | ind Addres                  | ss of Facility Fo                                   | ort Linc  | oln                                  | Funera                                    | 1 Home   |                                      |                    |
|                     | hysician  |                  | 23a. Part1. Enter the dis<br>shock, or heart fail<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)                         |  | lications that caused one cause on each lin   |                |                                |                         |                             | g, such as cardia                                   | c or respiratory a                              | rrest,                               |   | Appro-<br>Interva<br>Onset                         | ximate<br>al Betwe<br>and De<br>Year | eath               |
|                     | y physician and the purial-transit  | ledical Examiner | Sequentially list conditionally list conditionally cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | ns, lett                                       | Due to (or as a b. Ischeria Due to (or as a d   | c Hea          | rt Di                          | seas                    | e                           |   |   |                                      |   | 20 3   |                                      |                    |
| · Box               | 5,60  | Physician/Me     | IF FEMALE: 23b. Was decedent pregin the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | ths?   | 23c. If yes, outcome particles of the control of t | 2 🗌 Fetal d    | eath 3□                        | Ectopic<br>Other (      | pregnancy<br>specify)       |   |   |                                      | 23d. Date of o<br>Month                   | lelivery<br>Day                                    | Ye                                   | ear                |
| rds, P.O            | n signed by   | b                | Part II. Other significant<br>Rena1  | t conditions co<br>Failur                      |   | it not resulti | ng in the u                    | nderlying               | cause give                  | en in Part I.                                       |   | obacco i<br>Yes 2                    | use contribute                            | to the caus  |                                      |                    |
|                     |   | Completed        |  |  |   |                |                                |                         |                             |   | 24a. Was<br>autoj<br>perfo<br>1 Yes             | an<br>osy<br>ormed?<br>2 <b>X</b> No | nrior t                                   | autopsy find<br>o completion<br>?<br>es 2 \( \) No | of cau                               | vailable<br>ise of |
| r Vital             | is certifica  | o Be             | 25. Was case referred to examiner? 1 ☐ Yes 2 No  | -  | Hospital:<br>1 ☐ Inpatie  | nt 2∐EF        | R/Outpatien                    | it 3 🗆 🗆                | Othe                        |   | ath <i>(Check only c</i><br>Home <b>XX</b> Resi |                                      | 6 □Other (S)                              | pecify)  | -                                    |                    |
| DIVISION OF         | ath.<br>or: After this<br>ne funeral di   | ation: T         | 2 Accident   | ☐ Pending investigation                        | 28a. Date of Injur<br>(Month, Day   | Year) 2        | 8b. Time of<br>Injury          | f<br>M                  | 28c. Injur<br>Worl          |   | 28d. Describe                                   |                                      |   |  |                                      |                    |
| DIVISION OF VITA    | irs after de<br>ral Directo   | Certification:   | 4 ☐ Homicide   | Could not be determined                        | 28e. Place of inju<br>building, etc   | : (Specify)    | -13.                           |                         |                             |   | 28f. Location (<br>City or To                   | vn, State                            | e)  |  | Numbe                                | er,                |
| the Hoer            | within 24 hours and the Funeral completely filled   | Medical          | 29a. Certifier 1 - (Check only 2 one)  | Certifying Phy<br>Medical Exam                 | rsician: To the best of<br>iner: On the basis of<br>and manner sta  | examinatio     | edge, deati<br>n and/or in     | n occurre<br>vestigatio | d at the tir<br>on, in my o | ne, date and plac<br>pinion, death occ              | e, and due to the<br>urred at the time,         | cause(s<br>date an                   | ) and manner<br>d place, and d            | as stated.<br>lue to the ca                        | use(s)                               |                    |
| ‡ <u>c</u> L        | withi<br>To th  | M                | 29b. Signature and title o   | of certifier  Lul                              | She   | M              | )                              |                         | 9c. License<br>D 002        |   |   |                                      | te signed ( <i>M</i> o<br>8/2008          | nth, Day, Ye                                       | ear)                                 |                    |
| R                   | (4)   |                  | 30. Name and address of Michael A  | . Schwa  | artz, MD  | 750            | 0 Han                          |                         | Park                        | way, Su   | ite 204   | Gre                                  | enbelt                                    | , MD   | 207                                  | 770                |
| Pa .                | Sta<br>Registr  |                  | 31. Date filed (Month, Da  |  | 32. Registra  |                | re                             |                         |                             |   |   |                                      |   |  |                                      |                    |

DHMH 17 Rev 1/2001

burial-transit P.O. Box 68760 nding physician law requires that the death certificate be as the Records, Division or Vital death.

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 01/24/2008 **Physician** 2:10 a<sup>M</sup> Mary Barbara Okonek /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14512 Kelmscot Drive Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 X F 86 Ohio 288-12-7124 June 02, 1921 **Director** Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mertial Hygiene. Important: If time 27 is anarked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 K No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14512 Kelmscot Drive 20906 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. þ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Management U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Musci ပ္ Agatha Pernola 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Okonek - Daughter 710 Kent Oaks Way, Gaithersburg, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▲ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parklawn Memorial Park 02/04/2008 Rockville, Maryland 21. Signature of Juneral Service Licenser 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. -11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 weeks Respiratory Distress Syndrome disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sjogren's Syndrome 40 years Sequentially list conditions. Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Spinal Stenosis 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Chronic Pain autopsy performe To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 1 ☐ Yes 2 ☑ No Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 2 1 | Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours arer death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D32817 30. Name of address of person who completed cause of death (Item 23a) (Type, Print) M.D., 12016 Georgia Avenue, Wheaton, Maryland 20902 M. Wajeed Khan, 31. Date filed (Month, Day, Year) 32. Fistrar's Signature State 2008 IAN 28 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:38 а м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien, Taneytown Taneytown Carroll 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Min 205-16-5384 1 MM 2 □ F 82 Months Days Director Maryland Dec 8, 1925 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Carroll Taneytown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21787 45 Middle Street USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1954 1 X Yes 2 If Yes, Give 2 No 1 Never Married 21 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: white 3 ☐ Widowed 4 ☐ Divorced 1956 Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Appliances Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Ann Felly Glenn E. Ohler 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta 45 Middle Street, Taneytown, MD 21787 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any Injury or other trau Clara R. Ohler, wife 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Mt. Pleasant Cem. 1 ■ Burial 2 □ Cremation 3 □ Removal from State 1/29/2008 Taneytown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E. Baltimore St, Taneytown, MD 21787 ust. who 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final **Physician** Bruis Gerebro-2222012 Accident disease or condition resulting in death) Right Lerge /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine the death certificate be executed the burial-transi and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, led by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9 Linknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 No 1∐ Yes 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 1 ☐ Yes 2 ☑ No 4 ☑ Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: i or Attending Fafter death. 1 Natural 5 Pending Injury after death. I Director: Af d in by the fui investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) WIL

Registrar DHMH 17 Rev 1/2001

STIVA

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 01 Physician Day Levora Jeanette Proctor 25 2008 0912 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PG Southern Maryland Hospital Clinton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/21/1941 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours Washington, D.C. 579-54-4218 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No Director MD PGDistrict Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 2119 Hardwood Road U.S.A. Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No þ Specify Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) A.A.S. Elementary/Secondary (0-12) Prayer Warrior Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward R. Hurt Mariah S. Mack ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Della T. Streat — Daughter 2119 Hardwood Road; District Heights, Maryland 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cametery 02/01/2008 Clinton, Maryland 22. Name and Address of Facility Freeman Funeral Services 21. Signatu 4594 Beech Road; Temple Hills, Maryland 20748 En er the disease, or homplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enjer the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of). Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 2 **N**0 9 Unknown Part II. Other significant conditions contributing to death but not re esulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed 1∐ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 Z No 1 Inpatient P 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, o. ۵. or Vital Records, Division

The law requires that the death certificate be executed

ral", or items 23a or 28a-f show Examiner must be notified at

"natural",

other traumatic event, the Medical

is marked other than

Department of Health Important: If item 27

Physician

/Medical

**Examiner** 

burial-transit

the

attending physician for use as the buris

signed by t

certificate

After

death.

Hospital or Attending

injury or

Sus

72 hours after

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director:
completely filled in by the?

State Registrar

Medical

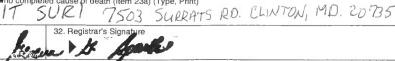
31. Date filed (Month, Day, Year) 2008 JAN 29

29b. Signature and title of certifier

30. Name and address of person

29a, Certifier

(Check only one)



no completed cause of death (Item 23a) (Type, Print)

and manner stated.

Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

62200

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2000

|  |                | 1 - State<br>Registrar   |   | Cer                           | tificate of l                                       | Death   | Reg  | J. No.                             | UO   | UHU  | 14               |
|--|----------------|--|---|-------------------------------|---|---|--|------------------------------------|--|--|------------------|
| Physicia   | an             | 1. Decedent's Name (First, Middle, Last)   |   |                               |   |   | Date of Death     Month                        | Day                                |  | 3. Time of De                              |                  |
| /Medic   |                |  | ewyne Purdie  | e, Sr.                        |   |   | January  |                                    |  | 7:55 A                                     | M . M            |
| Examin   | er             | 4a. Facility Name (If not institution, give str 5179 Clacton Av  |   |                               | 4b. City, Town, or Suit1:                           | r Location of Death                             |  | 4c. County o                       |  | raec                                       |                  |
| Funeral  | -              | 5. Social Security Number 6. Sex   | 7. Age (In yrs. la  | st birthdav)                  | If Under 1 Year                                     |   | 8. Date of Birth                               |                                    |  | e (State or F                              | Foreian          |
| Funeral<br>Director  |                |  | 1 2□F 61  | Yrs.                          | Months Days   | Hours Min.                                      | 8. Date of Birth<br>(Month, Day, Y<br>Cebruary | ear 1 940                          | Country  | )_ '                                       | oreign           |
| yland<br>now<br>at   |                | 10a. State 10b. County   | 10c. City,  | Town or Loc                   | ation   |   |  |                                    | 10d.   | Inside City I                              | Limits           |
| Mar<br>a-fsh<br>iffied   | ctor           | Maryland Prince Ge   | orges S   | Suitla                        | nd  |   |  |                                    |  | 1X Yes 2                                   | □No              |
| th the<br>or 28  | Director       | 10e. Street and Number   |   |                               | 10f. Zip Code                                       |   | 10g  | g. Citizen of Wi                   | nat Country                                      | ?  |                  |
| ath w  | ral            | 5179 Clacton Aven  |   |                               | 20746   |   |  | United                             |  |  |                  |
| er de«<br>items  | Funeral        | 11. Marital Status   | . Was Decedent Ever in U.S<br>Armed Forces US Nav                             | . 13. W                       | as Decedent of Hi<br>Yes, specify Cuba              | lispanic Origin? (Spe<br>an, Mexican, Puerto F  | cify Yes or No-<br>Rican, etc.)                |                                    | <ul> <li>American</li> <li>White, etc</li> </ul> |  |                  |
| 36<br>rs afte  | by F           | 1 Never Married 2 Married 3 Widowed 4 Divorced   | 1 X Yes 2 No<br>If Yes, Give March<br>Year or Date March                      | 1963                          | □Yes 2 <b>X</b> No                                  | Specify:  |  | Specify:                           | B1ac   | k  |                  |
| 2 hou  | led            | 15. Decedent's Educa   | tion  | 16a. Deced                    | ent's Usual Occup                                   | ation   | 16   | l<br>6b. Kind of Bus               | iness/Indus                                      | try  |                  |
| 215<br>thin 7<br>an "n<br>Medi   | ple            | (Specify only highest grade of Elementary/Secondary (0-12)   | College (1-4or 5+)  |                               |   | during most of working  d)                      |  | S. De                              | -  |  | th               |
| Ind 21215-0036  be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at  | Completed      | <u></u>  | years   | Soc1al                        | Service   | Represent                                       |  |                                    |  | vices                                      |                  |
| Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Marylan th and Mental Hyglene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at  | Be             | 17. Father's Name (First, Middle, Last)  (unknown)   |   |                               |   | 18. Mother's Name  Agatha                       | (First, Middle, Ma                             |                                    | )  |  |                  |
| aryla<br>should<br>and Men<br>s marke<br>umatic  | 은              | 19a. Informant's Name/Relationship (Type   | Print)  | 19h Mailine                   | Address (Street                                     | and Number or Rura                              |  |                                    | tata Zin Ca                                      | nda)                                       |                  |
| Ma<br>Ind 2 (  |                | Linda Gail Ruffin  | Purdie (Wife)   | 5179                          | Clacton   | Avenue; S                                       | Suitland,                                      | Mary1                              | and 2  | 0746                                       |                  |
| altimore,<br>mit. Pages 1 ar<br>partment of Hea<br>portant: If item:<br>y injury or other  |                | 20a. Method of Disposition  1  | novar from State  |                               | ition (Name of<br>eatory or other plac<br>Cheltenha | Feb.1,  | ,2008   Cl                                     | oc. Location - C<br>neltenh<br>ery | am, Ma   | , State<br><b>rylan</b> d                  | 1                |
| Baltimo permit. Page Department o Important: If any injury or  |                | 21. Signature of Fineral Servic Agree ed   | 00/1  | > 22                          | Name and Addres                                     | ss of Facility Compa                            | nv Morti                                       | cians.                             | Inc.   |  |                  |
| m Egera  | 1 .1           | Landigh  | D. Jour   | 6                             | 00 Kenne  | dy Street,                                      | N.W.; W  | lashing                            | ton,D  |  | 011              |
| *<br>  | 8              | 23a. Part1, Enter the disease, or complica shock, or heart failure. List only one                      | tions that caused the death.<br>cause on each line.                           | Do not ente                   | r the mode of dyin                                  | ig, such as cardiac o                           | r respiratory arres                            | t,                                 | In   | pproximate<br>terval Betwe<br>nset and Dea | en               |
| Physician<br>/Medical  |                | Immediate Cause (Final disease or condition resulting in death)  | Prostate Can  |                               |   |   |  |                                    |  | years                                      |                  |
| Examiner   |                |  | Due to (or as a conseque  | ence of):                     |   |   |  |                                    |  |  |                  |
| 上三季宝   | e.             | Sequentially list conditions, if any, leading to immediate   | Due to (or as a conseque  | ence of):                     |   |   |  |                                    | -  |  |                  |
| outed<br>id<br>ansit   | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events c. |   |                               |   |   |  |                                    |  |  |                  |
| o,<br>e exectan an a  |                | resulting in death) Last   | Due to (or as a conseque  | ence of):                     |   |   |  |                                    |  |  |                  |
| x 68760, ertificate be executed ling physician and e as the burial-transit   | Medical        | d.   |   |                               |   |   |  |                                    |  |  |                  |
| BOX 68760, eath certificate be executed attending physician and for use as the burial-transit  | _              | IF FEMALE:   | . If yes, outcome pf pregnan  | CV                            |   |   |  |                                    | 4  |  |                  |
| BO<br>leath c  | cian           | in the past 12 months?   | 1 ☐ Live birth 2 ☐ Fetal (  | death 3                       | Ectopic pregnancy<br>Other (specify)                | 1   |  | Mon                                | of delivery<br>th Da                             | y Yea                                      | ar               |
| Hecords, P.O. Bo. The law requires that the death of the has been signed by the attendage 2 should be detached for us.   | Physician      | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 9□ Unknown  |                               | (4, 44, 7   |   |  |                                    |  |  |                  |
| s that   | by PI          | Part II. Other significant conditions contr  | -   | _                             | derlying cause give                                 | en in Part I.                                   | 23e. Did toba                                  | cco use contrib                    | oute to the                                      | cause of dea                               | ith?             |
| COTGS, P   | edt            | Chronic Kidney D   | isease on Dia   | lysis                         |   |   | 1 ☐ Yes  | 2 □ No 3                           | B Probab   | ly 4 <b>⊠</b> Un∤                          | known            |
| law ras be 2 shr   | Completed      | Diabetes Mellitu   | 5   |                               |   |   | 24a. Was an autopsy                            | 24b. W                             | ere autopsy                                      | findings ava                               | ailable<br>se of |
|  | Com            |  |   |                               |   |   | performe                                       | ed?   de                           | eath?<br>Yes 2                                   |  | 50 01            |
| VITA<br>Ician:<br>Sertific<br>ector,   | B              | 25. Was case referred to medical examiner?   | nital:  |                               | 1046  | 26. Place of Death                              | (Check only one)                               |                                    |  |  |                  |
| Phys<br>this a   | P<br>L         | 1 Yes 2 No   |   | R/Outpatient<br>28b. Time of  |   | 4 Li Nursing Hon                                | ne 5 X Resident                                |                                    |  |  |                  |
| ding F<br>ding F<br>h.<br>After<br>funer   | ion            | 1 XNatural 5 ☐ Pending   | (Month, Day Year)   | Injury                        | 28c. Injun<br>Work                                  | yat<br>k?<br>Yes 2 □ No                         | od. Describe now                               | injury occurre                     | a  |  |                  |
| LIVISION OF all or Attending Phy after death. I Director: After this d in by the funeral d   | fica           | 3 Suicide 6 Could not be   | 28e. Place of injury - At hor   | ne, farm, stre                |   |   | 8f. Location (Stre                             | et and Number                      | r or Rural R                                     | oute Numbe                                 | er,              |
| al or all | Certification: | 4 ☐ Homicide determined  | building, etc. (Specify)  |                               |   | ļ   | City or Tòwn,                                  | State)                             |  |  |                  |
| DIVISION OF VITA Within 24 hours after death.  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,  | Medical (      | 29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine                                  | ian: To the best of my know r: On the basis of examination and manner stated. | ledge, death<br>on and/or inv | occurred at the tin<br>estigation, in my o          | me, date and place, a<br>ppinion, death occurre | and due to the cau<br>ed at the time, dat      | se(s) and man<br>e and place, a    | ner as state                                     | ed.<br>e cause(s)                          |                  |
| To the within 2 To the Complet   | Me             | 29b, Signature and title of certifier  | $\overline{a}$  |                               | 29c. License  | e number  | 290  | I. Date signed                     | (Month, Da                                       | y, Year)                                   |                  |
| 7  |                | > Lauret &   | lerry   |                               | DC-   | 18561   | J  | anuary                             | 29,  | 2008                                       |                  |
| 16   |                | 30. Name and address of person who com   | oleted cause of death (Item 2   | 23a) (Type, F                 | rint)   |   |  |                                    |  |  |                  |
|  |                | David J. Perry, M.   |   |                               | et, N.W.  | ; Suite C                                       | -2151;Wa                                       | shingto                            | on,D.C   | 200  | 10               |
| Star<br>Registra   |                | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signatu   | ire                           |   |   |  |                                    |  |  |                  |
| DHMH 17 Rev 1/20   |                | JAN 3 0 2008   | sens 15 A   | DEALL!                        |   |   |  |                                    |  |  |                  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Ruth Loretta Phillips January 24 2008 10:35a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 219-30-3250 73 **Director** April 8, 1934 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 907 Mark Road 21225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 XNo 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) filed withir Hygiene. College (1-4or 5+) homemaker 8 own home marked other alth and Mental Hw 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Darius Hodgson Ida Louise Condon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Connie Folderauer 907 Mark Road, Baltimore, MD daughter 21225 permit. Pages 1 an Department of Heal Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) East New Market Cem. 1/29/08 East New Market, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CANCEL UNKNOWN /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and stranger than the purial-tranger Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by PERIPHERAL VASCULAR DISPASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown CARDIOMYOPATH 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Viital 1 2 NO funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Tother (Specify) H D5/102 Certification: To 5 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending **Vision** 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and add

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AMPIRE COLUMBIA, MD

of person who completed cause of death (Item 23a) (Type, Print)

2008

08-01008 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Stephen Anthony Powell State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day February 4, 2008 **Medical Examiner** 1500 hrs Stephen Anthony Powell 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or oreign Country) Director Months Days Hours 215-78-9334 1 X M 2 39 Yrs August 9 1968 MD Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits MD Carroll 1 XYes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Westminster Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 48 Pennsylvania Avenue Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 X Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2 X No Widowed Divorced f Yes, Give Yea Yes 2 X No specify: White Specify: à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 event, the Medical 12 Disabled N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Theodore Anthony Powell Mary Jane Badalucco 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dixie Powell/wife 48 Pennsylvania Avenue Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 02/09/2008 Burial 2 Cremation 3 or other crematory or other place) Removal from State Department o Meadow Branch Cemeter Westminster, MD Donation 5 Other Specify: 21. Sign whe of Funeral Service Licensee Princip Aftinerativ Home and Chapel, P.A. 412 Washington Road Westminster, MD Part I. Effective disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and failure. List only one cause on each /Medical Death Pulmonary thromboemboli Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): b. Deep vein thromboses Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical 28f per ME g8/7 amh 3/13/08 PMENDED a-b, PII,27,28a-f, perME,g8/6, 2/20/08 TT X UNPENDED been signed by the attending physician should be detached for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery þ Completed

The law requires that the death certificate be Division of Vital Records, P.O. Box 68760,

certificate has l this After To the Funeral Director: 24 hours after death.

Be

Certification: To

Medical

| 230. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown | 1 Live birth 2 Fetal de: 4 Pregnant at time of death 5 Other (\$ 9 Unknown |                              | ncy  | Month Day                | Year                                 |
|---|--|------------------------------|--|--------------------------|--------------------------------------|
| Part II. Other significant conditions co                                | ntributing to death but not resulting in the underly                       | ying cause given in Part I.  | 23e. Did tobacco u                           | ise contribute to the ca | ause of death?                       |
| Compartment syndro  | me with fasciotomy & debride   | ement left                   | 1 Yes 2                                      | No 3 Probably            | 4 <b>U</b> nknown                    |
| lower leg   |  |                              | 24a. Was an autopsy performed? 1 ✓ Yes 2 No  | death?                   | findings available etion of cause of |
| 25. Was case referred to medical  |  | 26.Place of Death (Check     | only one)                                    | ٠                        |                                      |
| examiner?<br>1 ✓ Yes 2 No   | oital: 1 Inpatient 2 ✔ ER/Outpatient 3                                     | I Othor:                     | g Home 5 Resider                             | nce 6 Other:             |                                      |
| 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day, Year) 28b. Time of Injury              | 28c. Injury at Work?         | 28d. Describe how inju                       | ry occurred              |                                      |
| Natural 5 Pending  2X Accident Investigation                            | 12/12/2007 unk   | 1 Yes 2 X No                 | subject fell                                 |                          |                                      |
| 3 Suicide 6 Could not be  | 28e. Place of Injury - At home, farm, street, fact                         | ory, office building, etc.   | 28f. Location (Street and 48 or Town, State) | nd Number or Rural Ro    | oute Number City                     |
| 4 Homicide determined   | (Specify) residence  |                              | Pennsylvan                                   | ia Ave Apt 1             | Westminste                           |
|   | To the best of my knowledge, death occurred at                             |                              |  |                          |                                      |
| one) 2 Medical Examiner: On an  | i the basis of examination and/or investigation, in<br>d manner stated.    | my opinion, death occurred a | t the time, date and plac                    | ce, and due to the caus  | se(s)                                |
| 29b. Signature and title of certifier                                   |  | 29c. License number          | 29d. D                                       | ate signed (Month, Da    | ay, Year)                            |

30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

February 5, 2008

31. Date filed (Month, Day, Year) State Registrar FFB 0 strar's Signature

MSI

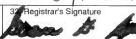
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** Year vennet Jan. 23 /Medical 2008 4a. Facility Name (If not institution, give street and nu 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosemont Dorchester ambrida 1 Year | If Under 24 He. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 😿 F Days Hours 215-26-722 Usual Residence of Decedent Director June 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits fshow ral", or items 23a or 28a-f shov Examiner must be notified at MD 1 √Yes 2 No Director Dorchester the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code death with Avenue Rosemont USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify Black 3 ₩Widowed 4 Divorced Completed ortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w. Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other transment. Homenaker OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (runknown ames ဥ Edwards 19a. Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vardell 120 Hill Road Landover, Maryland 20785

(Name of Date 20c. Location City or Town, State Lamberson 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Bethel 1/30/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of acility 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, MD-21613 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARDIAC ARREST /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): CAREDIOVASCULAR MONIC sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760 physician Physician/Medical the as attending I IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 ■Unknown Completed Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed 2 No Division or Vital 1 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 P Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) JAN 2 9



DENTON MD 21629

| 08-00683      |  |  |  |  |  |  |  |  |
|---------------|--|--|--|--|--|--|--|--|
| Dominic Reese |  |  |  |  |  |  |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Medical Examiner January 24, 2008 1425 hrs Dominic Demetrice Reese 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Prince George's Cheverly 5. Social Security Number If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or Foreign Cheverly 7. Age (In yrs. last birthday) **Funeral** Hours Director Months : Days Country Maryland 218088227 1x M 2 F 22 04/04/1985 Usual Residence of Decedent any 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 X Yes 2 No Maryland Prince Georges Takoma, Park death with the Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8314 Roanoke Avenue # 6 20912 United States 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White, etc. 1 X Never Married 2 Married Yes within 72 hours after Widowed Divorced If Yes, Give Year Yes 2 X No specify: Specify:Black ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygene. Important: If item 27 is marked other than "na rightry or other transmite event, the Medical Exp. during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Student Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Phillip Darnell Reese
19a. Informant's Name/Relationship (Type, Print) Melinda Renee' Holland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melinda Renee' Reese / Mother # 6 Takoma Park, Maryland 20912
Date | 20c. Location - City or Town, State 8314 Roanoke Ave 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Harmony Memorial Park 01/30/2008 Landover, Maryland Donation 5 Other Specify 22. Name and Address of Facility Pope Funeral Homes, P. A. 21. Signature of Funeral Service V censee 5538 Marlboro Pike Forestville. Maryland nd 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Approximate Interval Between Onset and /Medical a. Gunshot Wound of Head Death Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause Enter Uncertyin, Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial - tra Physician/Medical UNPENDED AMENDED Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) y the attached f 1 Yes 2 No 9 Unknown a Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 V No 3 Probably 4 Completed ficate has been s page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 🗸 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) Division of Vital Be examiner? Other<sub>4</sub> Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this ۵ 1 Yes After th 28a. Date of Injury (Month, Day,Year) FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot 1 FOUND: Natural meral Director: , y filled in by the f Pending Yes 2 V No hours after death. Jan 17, 2008 2144 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 409 Armstrong Court, Laurel, MD 24 hours at Funeral I determined (Specify) Stairwell 4 Momicide 29a. Certifier cal Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 0 and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 26, 2008 ell 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Florence L. Slaughter 01/24/2008 8:42 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Comm. Hospital Cheverly Prince Georges If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖾 F Hours Director 578246653 96 03/30/1911 Washington, D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits ıral", or items 23a or 28a-f show Examiner must be notified at Y☐Yes 2☐No Directo Maryland Prince George's Brentwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3702 Perry Street 20722 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. ☐ Yes 2 Yes, Give 1 Never Married 2 Married 2**√** No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No \$ Specify:Black 3 Widowed 4 □ Divorced Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Daniel Shorter Mary Winsmore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Delaney / Daughter 3701 Perry St. Brentwood, Maryland 20722 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Alexandria, Va 4 Donation 5 Dother (Specify) Metropolitan 01/31/2008 21. Signature of Funeral Service 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Md 20747 23a. 7 1) Enter the disclard, or como cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 | Yes 2 | No 3 | Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Itark way JAN 2 9 2008 32. Registrar's Signaty

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Hanover

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

174804

Maryland

01/26/2008

should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

|   | Immediate Cause (Final disease or condition resulting in death)   | WIDELY METASTATIC CA   | - Cuvh Onset and Death   |
|---|---|--|--|
|   |   | Due to (or as a consequence of):  b.   | ,  |
| miner                                   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a consequence of):   |  |
| lical Exa                               | resulting in death) Last  | Due to (or as a consequence of):   |  |
| Completed by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown   | 23d. Date of delivery<br>Month Day Year  |
| ed by Pr                                | Part II. Other significant conditions of  | ontributing to death but not resulting in the underlying cause given in Part I.  | 23e. Did tobacco use contribute to the cause of death?  1 Ves 2 No 3 Probably 4 Unknown  |
| Complet                                 | ,   |  | 24a. Was an autopsy performed?  1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No |
| Be                                      | 25. Was case referred to medical examiner?  | 26. Place of Death   | (Check only one)   |
|   | 1 ☐ Yes 2 No  | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom   | ne 5 Residence 6 Other (Specify)   |
| ation:                                  | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation  | (Month, Day Year) Injury Work?  M 1 ☐ Yes 2 ☐ No   | 8d. Describe how injury occurred   |
| ertific                                 | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   | Rf. Location (Street and Number or Rural Route Number,<br>City or Town, State)   |
| Medical Certification: To               | 29a. Certifier 1 Certifying Ph<br>(Check only one) 2 Medical Exam   | ysician: To the best of my knowledge, death occurred at the time, date and place, a niner: On the basis of examination and/or investigation, in my opinion, death occurre and panner stated. | and due to the cause(s) and manner as stated. and at the time, date and place, and due to the cause(s)                             |
| Me                                      | 29b. Signature and title opertifier   | Henty D 29c. License number D 21438  | 29d. Date signed (Month, Day, Year)  Sonuary 25 208  |
|   | 30. Name and address of person who  | completed cause of death (Item 23a) (Type, Brint) DEYENSE HE   | HWAY ANNAPOUS MO21401  |

Registrar DHMH 17 Rev 1/2001

State

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day Vear Orville Macey Slye, Sr. 10:05 aM January 2008 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 ☐ F Yrs Director 225-30-2579 101 October 3, 1906 Wisconsin Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14705 Cobblestone Drive 20905 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☒ No Specify. <u>م</u> Specify: 3 XWidowed 4 ☐ Divorced White Completed injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygien
Important; if item 27 Is marked other thi Statistician Census Bureau 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Edwin Slye Emma J. Jansky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne S. Valentine - Daughter 7903 Inverness Ridge Road, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 图 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 01/29/2008 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. on 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complicate his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List my are cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-trar and Due to (or as a consequence of): Physician/Medical as the l IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) Records, P.O. a∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Tyes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other:  $4 \square$  Nursing Home  $5 \square$  Residence 6 Nursing Home  $5 \square$  Residence 6 Other (Specify) Hospice Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🕱 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D0064615 January 25, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Anne Wroblewski, M.D., 1355 Piccard Drive, Rockville, Maryland 20850

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

Box 68760.

Division or Vital

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () 8 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 2008 JAN. 23, 12:30P M SCANTLEBURY ATHILL Α. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 30, 1918 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 XM 2 ☐ F Barbados 89 Director 580-01-6177 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Howard Laurel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20723 U.S.A. 8606 Woods End Drive Funeral permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Owner yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adrianna Hines Charles Scantlebury 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8606 Woods End Drive, Laurel, MD 20723 A. Jean Warden (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 ☐ Other (Specify) of Heaven Cem 1/28/08 Silver Spring, MD 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Altered Mental Status Charges Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Pulmonary Emboli physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical Dementia SBS IF FEMALE: use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 2 | Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2/2 No 1□ Yes Division or Vital funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ZNNo 1X Inpatient 2 ER/Outpatient 3 □ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1X Natural 1 ☐ Yes 2 ☐ No death. al or Attend s after death il Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral D 29a. Certifier 1 💢 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of pepting 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

38. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wan

D64874

1/23/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04052 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Shannon Katherine Saunders 2008 900 lanuary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula Regional Medical Center Salisbury Wicomico 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 1/28/2008 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 3 172-52-8014 Director MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Marylar 28a-f show ms 23a or 28a-f sh must be notifled NOYYes 2 No Director MD Philadelphia Philadelphia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3523 Fitler St. 19114 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. r than "natural", or iten the M-dical Examiner and 2 should be filed within 72 hours after ealth and Mental Hygiene. 1-52-8014 Baby Girl Saw 1XXNever Married 2 ☐ Married 1 □ Yes 2**X** If Yes, Give Year or Dates: 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHite ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 7 Is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael A. Saunders Kathleen Wauhop 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau Kathleen Saunders / mother 3523 Fitler St., Philadelphia, PA 19114 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial Pk 2/1/2008 Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Belin, MD 21811 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** treme /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a nonsequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed Exami burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 2008 9 Unknown 28 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 → No 3 → Probably 4 → Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 sl 1 TYes 2 12-1√10 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Matural Injury 1 ☐ Yes 2 🗆 No after death.

Director: / 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide in 24 hours the Funeral Director 1 ... rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely f To the and manner stated 29b. Signature and title of cegifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name an dress of person who completed cause of death (Item 23a) (Type, Print) Salisbury mD Carroll St. Son NS M. D. 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 3 0

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year DOMS E. SANVILLE Physician 24 2008 0440M /Medical 4a. Facility Name (If not institution, give street and number)

At Lunk C General H 4c. County of Death 4b. City, Town, or Location of Death Examiner War Cest Atlun HON, tal Balin If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 7. Age (Inlyrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1 M 2000F PENNSYLVANIA JUNE 15, 1930 161-24-0943 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County ir then "neturel", or Items 23s or 28e-f show the Medical Examiner must be notified at 1 Yes 2 □ No Directo DELAWARE SUSSEX SELBYVILLE 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number 15 2ND STREET 19975 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: WHITE Specify: Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BUSINESS MACHINES 12 CLERK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be ind Mantal I HUDSON BIRDA MURRAY ZENO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pagas 1 and 2 sl mant of Haalth an f Haalth a DEBORAH L. GRIFFIN/DAUGHTER P.O. BOX 976, SELBYVILLE, DELAWARE 19975 20b. Place of Disposition (Name of cemetery, crematory or other place) more, 20c. Location - City or Town, State 20a. Method of Disposition parmit. Pagas Dapartmant of I Important: If Ite eny injury or of once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CREMATORY OF DELMARVA 1/25/08 DELMAR, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final disease or condition resulting in death) COMMY **Physician** /Medical Due to (or as a consequence of): Examiner Sa uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner certificata ba exacutad that initiated events resulting in death) Last Due to (or as a consequence of): To Be Completed by Physician/Medical use as tha Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, None 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? performed? 1 ☐ Yes 2, Q No 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Latient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Aftar thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No daath. investigation the f after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) complately fillad in by 4 Homicide To the Hospital o within 24 hours aff To the Funerel Di TS Certifying Physician: To the best of my knowledge, death construct at the time, date and place; and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 24/08 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) 9733 ton tel

State Registrar

31. Date filed (Month Ray, 2009) 2008

DHMH 17 Rev 1/2001

he

32 Registrar's Signature

|                            |   |                              | For State   | State of   | Marylan                            | -                           | artment o   |   |                     | lental Hy                       | ygiene<br>Reg. No.                      | 200                               | 8                   | 04054  |
|----------------------------|---|------------------------------|---|--|------------------------------------|-----------------------------|---|---|---------------------|---------------------------------|---|-----------------------------------|---------------------|--|
|                            | Physici   | an                           | 1. Decedent's Name (First, Middle   |  | ESSL                               |                             |   | ,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                     | 2. Date of D<br>Month           |   | _ Y                               | ear                 | 3. Time of Death                                   |
| 100                        | /Medio  |                              | 4a. Facility Name (If not institution   | . –  |                                    |                             | 4b. City, Tow                                       | n, or Locatio                           | n of Death          | 01                              |   | County of                         |                     | 0700   |
| 7                          | Examin  | iei                          | Mandrin Chesap  |  |                                    | se                          | Harwo   | ood                                     |                     |                                 | P                                       | Inne i                            | Aru                 | ndel   |
|                            | Funeral<br>Director   |                              | 5. Social Security Number 576–58–5673   |  | 7. Age (In yrs.                    |                             | If Under 1 Ye Months Da                             |   | er 24 Hrs.<br>Min.  |                                 | irth<br>Pay, Year)                      |                                   | Birthp<br>Coun      | 37   |
|                            | p.  |                              | Usual Residence of Decedent   |  | 100 6                              | . Taum ar La                | action  |   |                     | - Care                          | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                                   |                     |  |
|                            | Marylan<br>a-f show<br>ified at   | tor                          | MD Anne   | e Arundel  | 100. 01                            | y, Town or Lo               | rills   |   |                     |                                 |   |                                   |                     | 0d. Inside City Limits 1 ☐ Yes 2X No               |
|                            | or 28   | Dire                         | 10e. Street and Number  |  |                                    |                             | 10f. Zip Coo  | de                                      |                     |                                 | 10g. Citiz                              | en of Wha                         | at Coun             | try?   |
|                            | ath w   | ra                           | 1010 Springhil  |  |                                    |                             | 210   |   |                     |                                 | USA                                     | 4.5                               |                     | 1.42   |
| 936                        | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | by Funeral Director          | 11. Marital Status  1 ☐ Never Married 2 ☐ Marr 3 ☒ Widowed 4 ☐ Divorced   | Armed Fo   | 2₩ No                              |                             | Was Decedent<br>If Yes, specify (<br>1 ☐ Yes 2X     | Cuban, Mexic                            | can, Puerto         | ecify Yes or N<br>Rican, etc.)  |   | 4. Race -<br>Black, '<br>Specify: | White,              |  |
| 21215-0036                 | "natura   | Completed                    | 15. Deceden<br>(Specify only highe  | t's Education<br>st grade completed)             |                                    | ı (Give                     | dent's Usual Oo<br>kind of work do<br>DO NOT use re | one durina m                            | ost of work         | ing                             | 16b. Kin                                | nd of Busin                       | ness/Ind            | Justry   |
| 212                        | 2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Me   | Somp                         | Elementary/Secondary (0-12)   | College (1                                       | -4or 5+)                           | Homen                       | _   |   |                     |                                 | Owr                                     | n Hom                             | e                   |  |
| Maryland                   | the file  | Be                           | 17. Father's Name (First, Middle, Yong Hwan Kim   | Last)  |                                    |                             |   |   | ther's Nam<br>Ok Ny | e (First, Middl<br>o Lee        | e, Maiden S                             | Surname)                          |                     |  |
| J.                         | should be fand Mental I<br>s marked of<br>umatic eve  | ျ                            | 19a. Informant's Name/Relations   | hip (Type. Print)                                |                                    | 19b. Mailir                 | ng Address (Str                                     |   |                     |                                 | ber, City or                            | Town, Sta                         | ate, Zip            | Code)  |
|                            | 1 and 2<br>Health a<br>tem 27 is  |                              | David Tessle  | er/Son   |                                    | 1211                        | _Hansor   | ı Way                                   | Seve                | rn, MD                          | 2114                                    | 14                                |                     |  |
| ore                        | t of He   |                              | 20a. Method of Disposition 1 Durial 2 □ Cremation   | 3 □Removal from                                  | State                              | cemetery, crei              | sition (Name o<br>natory or other                   | place)                                  | !<br>!              | Date                            |   | cation - Cit                      | •                   |  |
| Baltimore,                 | t. Pa<br>tmer<br>tant:  |                              | 4 □ Donation 5 □ Other (S   |  |                                    |                             | n Nat']<br>2. Name and Ad                           |   |                     |                                 |   | ingto<br>Home                     |                     | VA   |
| Ba                         | Depar<br>Impor<br>any Ir  |                              | Memb.   | Valde  | 1.10                               | 1                           | 512 NW  |   |                     |                                 |   | 207                               |                     |  |
| 100                        | Physician   |                              | 23a. P. rt1. Enter the disease,<br>shock, or heart failure. List<br>Immediate Cause (Final<br>disease or condition                |  | aused the deat<br>ach line.        |                             | er the mode of                                      |   |                     |                                 |   | /                                 |                     | Approximate<br>Interval Between<br>Onset and Death |
| 1                          | /Medical<br>Examiner  |                              | resulting in death)   | Due to (   | or as a conseq                     | uence of):                  |   |   |                     |                                 |   |                                   |                     |  |
|                            | pe sit  | iner                         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b. Due to (                                      | or as a consiq                     | uanca of):                  |   |   |                     |                                 |   |                                   |                     |  |
| 8760,                      | cate be executed oblysician and the burial-transit  | dical Examiner               | that initiated events<br>resulting in death) Last   | c  | or as a conseq                     | uence of):                  |   |   |                     |                                 |   |                                   |                     |  |
| P.O. Box 687               | The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit  | Completed by Physician/Medic | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown   |  | irth 2 ☐ Feta<br>ant at time of c  | al death 3                  | Ectopic pregn                                       |   |                     |                                 | 2                                       | 3d. Date o                        |                     | ery<br>Day Year                                    |
|                            | quires that<br>n signed by  | d by Pr                      | Part II. Other significant condition  | ons contributing to de                           | eath but not res                   | ulting in the u             | nderlying cause                                     | given in Pa                             | rt I.               |                                 | tobacco us                              | /                                 | ute to th<br>☐ Prob | ne cause of death?                                 |
| Division or Vital Records, | The law reate has bee bage 2 short  | complete                     |   |  |                                    |                             |   |   |                     | 24a. Wa<br>aut<br>per<br>1⊡ Yes | opsy<br>form <b>e</b> #?                | prio<br>dea                       | or to co<br>ath?    | psy findings available mpletion of cause of        |
| /ita                       | yslcian: The l<br>is certificate ha<br>director, page   | Be                           | 25. Was case referred to medica examiner?   |  |                                    |                             |   |   | ace of Deat         | h (Check only                   |   | 4                                 | M                   | ANDRIN   |
| or                         | Physician:<br>this certific<br>ral director,  | P                            | 1 Yes 2 No  | Hospital: 1 ☐ I                                  | ·                                  | ER/Outpatier<br>28b. Time o | IL S DOA  |   | Nursing Ho          | ome 5 Re                        |   | /                                 |                     | v) HOSPICE   |
| ision                      | uttending<br>death.<br>ctor: After<br>/ the fune  | Certification:               | 1 Natural 5 □ Pendir<br>2 □ Accident investi<br>3 □ Suicide 6 □ Could   | g (Moni  | th, Day Year)                      | Injury                      | М   | Injury at<br>Work?<br>1 ☐ Yes 2         | □No                 |                                 |   |                                   |                     | al Route Number,                                   |
| Ω                          | ital or Arsafter<br>ral Direction by  | Certi                        | 4 ☐ Homicide determ   | buildi   | of injury - At heng, etc. (Special | fy)                         | -   |   |                     | City or T                       | own, State)                             |                                   |                     |  |
|                            | To the Hospital or within 24 hours after To the Funeral Dir completely filled in I  | Medical                      |   | g Physician: To the<br>Examiner: On the band man |                                    |                             |   |   |                     |                                 |   |                                   |                     |  |
|                            | O T W TO W  | Σ                            | 29b. Signature and title of certifie  | 1366   | 2 NA                               | 1 un                        | 29c. Lic  | Dense number                            | 1438                | 3                               | 29d. Date                               | e signed (i                       | Month,              | Day, Year)   |
| f                          | (9)   |                              | MICHAEL -   | Who completed days                               | NA                                 | 441                         | Print) DE   | FEN                                     | SEH                 | 76+W/                           | Ay 1                                    | 4) NA                             | IAI                 | BLIS MOLIYA  |
|                            | Sta<br>Regist   |                              | JAN 3 0 2008  |  | egistrar's Signa                   | bole                        | •   |   |                     |                                 |   |                                   |                     |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene UUS 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year January 26, 2008 **Physician** 0543 Ethel Virginia Trainor /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Brooke Grove Rehabilitation and NUTSing Center Sanly Sprin Montgonery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 🛣 F 578-05-0632 91 Jan. 9, 1917 Washington, DC Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County rthan "natural", or Items 23s or 28s-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Montgomery Maryland Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9007 Garland Avenue 20901 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White 2√ Widowed 4 Divorced Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Private 12 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Pages 1 end 2 should be fil ment of Heelth end Mentel H tant: If Itam 27 ia marked ott Milton Lewis Whipp Edna Cochran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9007 Garland Avenue, Silver Spring, MD 20901 Lynn Turner/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Jan. 26, 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State 5 permit. Page Depertment of Important: If any injury or QDGE. Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Eaching Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 COEL 6 Lung 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE **Physician** CEREBRAL INFARCT WEEK /Medical Due to (or as a consequence of) Examiner YEARS LERE ISTO VASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The taw requires that the death certificate be executed ed by the attending physiclen and deteched for use es the buriet-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year 4☐ Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 1 Inknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PERIPHERAL VASCULAR SEVERE 1 Tes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available pnor to completion of cause of death? LOWER GANGRENE 24a. Was an WITH has autopsy this certificate 1 Yes 2 No 1 Yes 2 No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? 1 Natural s after dec. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide within 24 hours after de To the Funeral Diracto completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number owe my 733700 January 26, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SLADE SCHOOL SANDY SPRING, IED E HOWE 18100 31. Date filed (Month, Day, Year) JAN 28 32 egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                                |  |                | For<br>State<br>Registrar   | State of Maryland  |                                    | irtment of H<br>tificate of I                            |   | lental Hygie                                    | Z 11 11 6                              | 04056   |
|--------------------------------|--|----------------|---|--|------------------------------------|--|---|---|--|---|
|                                | Physici  | 4-             | 1. Decedent's Name (First, Middle, Last)<br>Evelyn Parks Thies  |  |                                    |  |   | 2. Date of Death  Month  January                | 24, 20ŏ8°                              | 3. Time of Death 10:50P. M                                      |
|                                | /Medic<br>Examin   |                | 4a. Facility Name (If not institution, give s<br>Washington Adventi   | treet and number)<br>st Hospital   |                                    | 4b. City, Town, or<br>Takoma                             | Location of Death                                       |   | 4c. County of Dec<br>Montgome          |   |
| 1 1000                         | Funeral<br>Director  |                | 5. Social Security Number 6. Sex 247-09-4386  | 7. Age (In yrs. It   |                                    | If Under 1 Year<br>Months Days                           | If Under 24 Hrs.<br>Hours Min.                          | 8. Date of Birth<br>(Month, Day, Y<br>Oct.31, 1 | 9. B                                   | rthplace (State or Foreign<br>Country)<br>Uth Carolina          |
|                                | Maryland -f show   | tor            | Usual Residence of Decedent  10a. State Maryland Prince Ge  |  | Town or Lo<br>lege P               |  |   |   |  | 10d. Inside City Limits Y Yes 2 □ No                            |
|                                | a with the   | i Director     | 9110 Autoville Dri  | ve   |                                    | 10f. Zip Code<br>2074                                    | <b>4</b> 0  |   | Citizen of What C<br>United S          |   |
| 036                            | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene important: if item 27 is marked other than "natural", or items 23a or 28a-f show apprigntry or other traumatic event, the Madical Examinar must be mullified at ODGe. | by Funeral     | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | I2. Was Decedent Ever in U.s<br>Armed Forces?<br>1 ☐ Yes 2 No<br>If Yes, Give<br>Year or Dates:  | 1                                  | Was Decedent of H<br>f Yes, specify Cuba<br>1 ☐ Yes 2 No | ispanic Origin? (Sp.<br>in, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)                | 14. Race - An<br>Black, Wh<br>Specify: |   |
| Baltimore, Maryland 21215-0036 | within 72 ho<br>ene.<br>than "natur<br>the Madical   | Completed by   | 15. Decedent's Educify only highest grade   | Coltege (1,4or 5+)   | 16a. Deced<br>(Give<br>life. Secre |  | ation<br>during most of work<br>1)                      | ing   | b. Kind of Busines                     |   |
| and 2                          | d be filed<br>ental Hygi<br>ked other<br>ic event.   | To Be Co       | 17. Father's Name (First, Middle, Last) Henry Parks   |  |                                    |  | 18. Mother's Name<br>Bessie Je                          | e (First, Middle, Ma<br>Ones                    | iden Sumame)                           |   |
| Mary                           | nd 2 shoul<br>lith and Mo<br>27 is marl<br>r traumati  | F              | 19a. Informant's Name/Relationship (Ty. John F. Thies, Jr.  |  |                                    |  |   | al Route Number, College Pa                     |  | , Zip Code)<br>land 20740                                       |
| imore,                         | Pages 1 ar<br>nent of Hea<br>ant: if item<br>ary or othe   |                | 20a. Method of Disposition  1   | emoval from State For  | t Linc                             |  | tery 1/30   | /2008 Br  |  | Maryland  |
| Balt                           | permit. Depertrimporte any inju  |                | 21. Signature of Funeral Service License Worked V. L  | Bergwoodt  | — D <sup>22</sup><br>44            | nald V. 1<br>00 Powder                                   | ss of Facility<br>Borgwardt<br>Mill Ro                  | Funeral<br>ad Beltsv                            | Home, PA<br>ille, Ma                   | ryland 20705  |
|                                | Physician<br>/Medical<br>Examiner  |                | 23a. Part1. Enter the disease, or compl<br>shock, or heart faifure. List only or<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | ne cause on each line.   | clen                               |  |   | or respiratory arres                            |  | Approximate<br>Interval Between<br>Onset and Death              |
|                                |  | Examiner       | Sequentially list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence to or as a conseq |                                    |  |   |   |  |   |
| 8760,                          | cate be executed obysicien and the burial-transit  | dicai E        | L.  | 1.   |                                    |  |   |   |  |   |
| O. Box 6                       | he death certificate be executed<br>the attending physicien and<br>ched for use as the burial-transit  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 3c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of di 9 Unknown  | Ideath 3[                          | Ectopic pregnance  | /   |   | 23d. Date of o                         | delivery<br>Day Year  |
| S, P                           | requires that the di<br>been signed by the<br>hould be detached  | ρ              | Part II. Other significant conditions con   | ntributing to death but not resi   | ulting in the u                    | inderlying cause giv                                     | ven in Part I.  | 23e. Did toba<br>1 ☐ Yes                        |  | to the cause of death?  Probably 4 Dunknown                     |
| of Vital Record                | The law<br>ate has b<br>page 2 s   | Completed      |   |  |                                    |  |   | 24a. Was an autopsy performe                    | prior to death                         | autopsy findings available o completion of cause of ? es 2 2 No |
| Vita                           | Physician: The this certificate ral director, pag  | Be             | 25. Was case referred to medical examiner?  | Hospitaf:  | <b>=0</b>                          |  |   | th Check only one                               | es 6 DOther (6                         | nanti)  |
|                                | g Physier this   | n: To          | 27. Manne Death   | 28a. Date of fnjury<br>(Month, Day Year)   | 28b. Time o                        | III JUDA   | 4 [   14013111g 1 h                                     | ome 5 Residen 28d. Describe how                 |  | Decity)   |
| Division                       | Attendin<br>death.<br>ctor: Af   | Certification: | 1 Setural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined  | 28e. Pface of Injury - At he   | ome, farm, st                      | M 1 🗆  | Yes 2 □No   |   |  | Rural Route Number,   |
| <u>S</u>                       | urs after<br>urs after<br>reat Dire  |                | 4   Hornicide   | building, etc. (Specif   |                                    |  |   | City or Town,                                   |  | as stated   |
|                                | To the Hospital or Attending Pr<br>within 24 hours after death.<br>To the Funeral Director: After it<br>completely filled in by the funeral  | edical         | (Check only 2 Medical Exami   | sician: To the best of my kno<br>ner: On the basis of examina<br>and manner stated.  | tion and/or in                     | nvestigation, in my                                      | opinion, death occu                                     | rred at the time, dat                           | e and place, and o                     | fue to the cause(s)   |
|                                | T with   | Σ              | 29b. Signature and title of certifier   | DI, M  | D                                  | 29c. Licens  | 06010   | 0   |  | 80-5  |
|                                | 70   |                | 30. Name and address of person who co   | empleted cause of death (Item<br>Aum En  |                                    | Print) 8.  | Silva   | Shry ,  | 156 U.D<br>MB 269                      | East<br>103   |
| 4                              | St<br>Regist   | ate<br>rar     | 31. Date filed (Month, Day, Year)  JAN 2 8 20   | 32 Registrar's Signa   | ture                               | arti   |   |   |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Evelyn Willey 2008 Trice Januar /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospita Dorchester Cambridge General If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 🖫 F 214-07-9338 87 5, Feb. 1920 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Dorchester Cambridge Director death with the Ma 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Race St., Apt. 304 21613 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Marylahd 21215-0036 1 ☐ Yes 2 ☐ Xio Specify. Specify: white Completed by 3 ₩Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) seamstress garment unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) T is mark Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any lulury or other traumatic evonce. Willey unknown Effie unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 Court Lane, Unit 602, Cambridge, MD William L. Wise 21613 p.r. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 1/29/08 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 22. Name and Address of Facility of Funeral Service Licensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 Tyes 2 □ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2□ No 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 3 DOA 1 Inpatient 2 ☐ ER/Outpatient After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Within 24 hours and
To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 503 BYRN ST, CAMBRIDGE, MD-31. Date filed (Month, Day, 32. Registrar's Signature State Registrar 2008

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 0849 (AM 26 2008 Tosch Name (If not institution, give street and nu lungh /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Examiner Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Min. Months Days Hours 1M 2□ F Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? Ràce - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify. Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be it Department of Health and Mental Important: If Item 27 is marked of any Injury or other traumatic eve 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type Print) 026 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Pocomoko 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bennis South Funeral Hom Paranox 23a. Part1. Enter the dis shock, or heart fall sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bleedilo **Physician** /Medical Examiner Gastnie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the a page 2 should be detached to 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? To the Hospital or Attending Physician: 26. Place of Death (Check only one Be Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name 600 N. Wolfe ST, Tonathan Therman 32 Registrar's Signature 31. Date filed (Month, Day, Year) JAN 3 0 State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Charles Udekwe JANUary 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Prince Georges **Examiner** Doctor's Hospital Lanham 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 214-51-1916 Months Days Hours Min 1**X** M 2□ F 33 Yrs Director Nigeria May 31, 1974 Usual Residence of Decedent 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Prince Georges Md. Lanham Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code Citizen of What Country? 20706 Nigeria 6316 Hardwood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: Black 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced "natural" Completed other than "natu vent, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Realtor Real Estate 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if item 27 is marked or other traumatic ev Eugene Nwude Agnes Ibe 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5103 Wiley Street Emmanuel A. Nwude (Brother) Riverdale, Md. 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any Injury or once. 02/06/2008 Lagos, Nigeria 4 Donation 5 Dother (Specify) Family Cemetery 21. Signature of Funeral Service Licensee Name and Address of Facility
J. H. Bacon Funeral Home, Inc.
47 14th Street, N.W. Washington, DC 1. C361 3447 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner we Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4□Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 2 10 deeth? 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 HER/Outpatient 3 □ DOA Certification: To this 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funerai Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1. Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

24 hours after of 24 To the I within 2.

law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

death with the Maryland

Baltimore, Maryland 21215-0036

EKWE

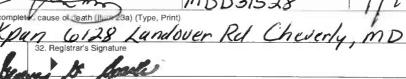
State Registrar

DHMH 17 Rev 1/2001

(Month, Day, Year) 2008

29b. Signature and title of certifier

rguret



Name and address of person who completed cause of eath (Illum 23a) (Type, Print)

29c. License number

MUD31528

29d. Date signed (Month, Day, Year)

08-00954 John Vucci

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 04060

| onin vacci   | 1- For State Certificate of L   |   | Reg. No.                                   |  |
|--|---|---|--|--|
| Physician/   | Decedent's Name (First, Middle, Last)   | 2   | Date of Death  Month  Day  February 2, 200 | 3. Time of Death 2345 hrs  |
| Medical Examine  | COM MICHORY VACCE   | . City, Town, or Location of Death  |  | c. County of Death   |
|  |   | Baltimore   |  |  |
| Funeral  | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)   | If Under 1 Year If Under 24Hrs.  Months Days Hours Min.                   | 8. Date of Birth (MM                       | /DD/YYYY) 9. Birthplace (State or<br>Foreign<br>Country) Virginia    |
| Director   | 215-76-0551 1x M 2 F 49 Yrs.  | Montals Days Flodis Min.  | Nov. 18,                                   | 1958 Country) VII gITTLE   |
| any  | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location   | 1   |  | 10d. Inside City Limits  |
| 00   |   |   |  | 1 Yes 2XX No   |
| the Marylanc as a cr 28a-f sh  | Maryland Baltimore Baltimor   | 10f. Zip Code   | 10g. Cit                                   | tizen of What Country?   |
| the Maryle sa or 28a-f piffed at or  |   | 21236   |  | USA  |
| r death with the Maryland or Items 23a or 28a-f show must be notified at once.   | 11. Marital Status 1 Never Married 2 Married Armed Forces? 12. Was Decedent Ever in U.S. 13. Was If Yes                       | Decedent of Hispanic Origin? ( Spe<br>s, specify Cuban, Mexican, Puerto F |  | <ol> <li>Race - American Indian, Black,<br/>White, etc.</li> </ol>   |
| er deat  |   | res 2 X No specify:   |  | Specify: White   |
| urs aft<br>tural"<br>mine  | 15 Decedent's Education (Specify only highest grade completed) 16a Decedent's   | S Usual Occupation (Give kind of we                                       | ork done 16b.                              | Kind of Business/Industry  |
| 5-0036 ed within 72 hour lygiene. other than "mate the Medical Exar Completed  | Elementary/Secondary (0-12) College (1-4 or 5+)   | at of working life. DO NOT use retire                                     | ed)  |  |
| 303(<br>within<br>iene.<br>ner tha<br>Medic  | 2 Steamfi   |   | First, Middle, Maider                      | HVAC   |
| 21215-0036 and be filed within 7 Montal Hygiene, marked other than c event, the Medica   |   |   | aria Tell:                                 |  |
| 212<br>hould be<br>d Ment<br>is mark<br>tic ever   |   | Address (Street and Number or R   | ural Route Number, 0                       | City or Town, State, Zip Code)                                       |
| more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ert of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shorr other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director   | Patti Jo Vucci/Wife 410   | 08 Loch Carrow R  | oad, Balt                                  | imore, MD 21236  |
| ore,<br>sslan<br>of Hea<br>If iter   | 1 Burial 2 Cremation 3 Removal from State crematory or other  | er place)   | eb. 7,                                     |  |
| Baltimore,<br>permit. Pages I an<br>Department of He,<br>Important: If ite   | 4 Donation 5 Other Specify:   | even Cemetery   |  | Silver Spring, Mary  |
| Baltir<br>permit. I<br>Departme<br>Importa<br>injury or  |   | me and Address of Facility  |  |  |
| Physician  | 23a. Part I. Enter he disease, or complications that cause the death. Do not enter the  | mode of dying, such as cardiac or   | respiratory arrest, sh                     | hock, or heart Approximate Interva                                   |
| /Medical   | failure. List only one cause on each line.  Immediate Cause (Final disease a. Heroin intoxication                             |   |  | Death  |
| Califfie   | or condition resulting in death)  Due to (or as a consequence of):  |   |  |  |
| <u> </u>   | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):                                |   |  |  |
| P ted  | cause. Enter Underlying Cause (Disease or injury that initiated  Due to (or as a consequence of):                             |   |  |  |
| P unted nd ransit  | events resulting in death) Last Due to (or as a consequence or).  d.  |   |  |  |
| 760, icate be executed physician and the burial - transit  | x UNPENDED AMENDED #23a,PII,27,28a-f. perME.  | g876, 2/21/08 TT  |  |  |
| 7760<br>ficate l<br>g phys<br>t the bu   | IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Feta                            | al death 3 Ectopic pregnal  |  | 3d. Date of delivery  Month Day Year                                 |
| Box 687 e death certific the attending p ed for use as th  | past 12 months?  past 12 months?  4 Pregnant at time of death 5 Other   | er (Specify)  |  |  |
| D. Bo tithe deal by the at ached for   | 1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the un       | ideduing course given in Part I   | 23e Did tobacci                            | o use contribute to the cause of death?                              |
| P.O.   | Cocaina use   | denying cause given in a are i.   |  | No 3 Probably 4 ✔ Unknown  |
| Division of Vital Records, P.O. and or Attending Physician: The law requires that the stand clearly all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach bartification: To Re Commisted by P. Partification:  | Cocarine dec  |   | 24a. Was an                                | 24b. Were autopsy findings available prior to completion of cause of |
| e law re has te bas te mol   |   | <del></del> -   | autopsy<br>performed1<br>1 ✓ Yes 2         |  |
| II Re  |   | 26.Place of Death (Check of   |  |  |
| F Vital Physiciam r this certical director   | examiner?  1 V Yes 2 No  Hospital: 1 Inpatient 2 V ER/Outpatient  |   |  | dence 6 Other:   |
| ing Pl   | .   27, Manner of Death   200, Time of high   | 1 Vac 2 V No  | 28d. Describe how it                       | njury occurred   |
| Sior<br>Attend<br>death<br>death<br>death<br>sy the  | Pending Investigation Prod 2/2/2008 Fnd 11;1 28e. Place of Injury - At home, farm, street                                     | 5 pm  | unk<br>28f. Location (Street               | t and Number or Rural Route Number, Cit                              |
| Division C<br>spital or Attending<br>hours after death.<br>neral Director: Af<br>/ filled in by the fun  | 3 Suicide 6 X Could not be determined (Specify) found in house  | , tablety, and banang, etc.   | or Town, State)                            |  |
| Hospin<br>24 hou<br>Funer.   |   | ed at the time, date and place, and                                       | due to the cause(s)                        | and manner as stated.  |
| Division of Vital Records, P.O. Box 687  To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the Mardinal Certification: To Re Commissed by Physician | one) 2 Medical Examiner: On the basis of examination and/or investigation   | on, in my opinion, death occurred a                                       | t the time, date and p                     | place, and due to the cause(s)                                       |
| - F F O E  | 29b. Signature and title of certifier   | 29c. License number   |  | d. Date signed (Month, Day, Year) ebruary 3, 2008                    |
|  | Pot Un- Vollet in   | O.C.M.E.  |  |  |
| pero+1   | 30. Name and address of person who completed cause of death (Item 23a) Patricia Arpnica-Pollak MD. Assistant Medical Examiner | 111 Penn Street, Baltimor   | e, MD 21201                                |  |
| Stat   | 31. Date filed (Month, Day, Year) Registrar's Signature   | 5.6   |  |  |
| Registra   |   | 2   |  |  |

Physician

/Medical

Examiner

Director

Funeral

Completed by

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Examiner

Physician/Medical

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Certification:

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After

Md.

**Funeral** 

Director

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#17.PerFHPGC1-30-08cm Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 2:03PM Tanuary Wilkes ,2008 Taylor 23 Jacqueline 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince Georges Doctors Hospital Lanham If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year Birthplace (State or Foreign Country) Days Min. Months Hours 1 ☐ M 2 🔯 F 53 578-74-8185 1/15/1955 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2X No Hyattsville Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20782 U.S.A. 1404 Asbury 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Black 1 ☐ Yes 2X No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) USDA Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Taylor Karriem Annie Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1404 Asbury Ct., Hyattsville, Md. 20782 Elijah Karriem- husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington 1/29/08 Adelphi, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig ture of Funeral Service Licensee. 22. Name and Address of Facility Universal Mortuary 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. DC20011 411 Kennedy St., N.W. Washington, Approximate Interval Between Onset and Death Immediate Cause (Final years <u>Metastatic</u> Cancer Breast disease or condition resulting in death) Due to (or as a consequence of): years Metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a puntacionence of months Pleural Metastasis Due to (or as a consequence of) years Liver Metastasis IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2X No 3 Probably 4 Unknown Colon Cancer 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2**X** No 1∏ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Xinpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending Injury 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

25. Was case referred to medical

and manner stated. 29b. Signature and the of certifier mo

29c. License number 29d. Date signed (Month, Day, Year)

1/24/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Melvin Gaskins Md. 7831 Belle Point Dr. Greenbelt, Md. 20770

D43162

31. Date filed (Month, Day, Year) 2008 JAN 3 0

32. Registrar's Signat

|              |  |                | For  |                  |                                | aryland                      |                               | rtment of H                               |                             | and Me                      | ntal Hyg                       | iene                 |                               |                                   |             |
|--------------|--|----------------|--|------------------|--------------------------------|------------------------------|-------------------------------|---|-----------------------------|-----------------------------|--------------------------------|----------------------|-------------------------------|-----------------------------------|-------------|
|              |  |                | 1 - State<br>Registra Amend#8.Per  |                  | -08ar                          |                              | Cer                           | tificate of l                             | Death                       |                             |                                | eg. No. 2            | 800                           | 011                               | 162         |
|              | Physicia   | an             | Decedent's Name (First, Middle   | e, Last)         |                                |                              |                               |   |                             | 2                           | . Date of Deat<br>Month        | Day                  | Year                          | 3. Time of                        |             |
|              | /Medic   |                | Dorothy  | Whee             |                                |                              |                               |   |                             |                             | January                        | 7                    |                               | 8:27                              | P M         |
|              | Examin   | er             | 4a. Facility Name (If not institution  |                  | ,                              |                              |                               | 4b. City, Town, or                        |                             | of Death                    |                                |                      | nty of Death                  | !-                                |             |
|              |  | <b>^</b>       | Southern Maryl 5. Social Security Number   | and Hos          |                                |                              | ast birthday)                 | Clintor<br>If Under 1 Year                |                             | 24 Hrs.   8                 | . Date of Birth                |                      |                               | orge's                            |             |
|              | Funeral Director   |                |  | 1 □ M 2 🔀        |                                | 50                           | Yrs.                          | Months Days                               | Hours                       | Min.                        | Date of Birth<br>(Month, Day   | (우급) 1,37<br>21 - 20 | 008 Wa                        | olace (State o<br>otry)<br>shingt | on. D       |
|              |  |                | 578-78-7565<br>Usual Residence of Decedent   |                  |                                |                              | ]                             |   |                             |                             | andar y                        | 219 21               | Spo na                        |                                   | 011, 1      |
|              | rylan<br>how   |                | 10a. State 10b. County   |                  |                                | 10c. City                    | , Town or Lo                  | cation                                    |                             |                             |                                |                      | 1                             | 10d. Inside Cit                   |             |
|              | aa-f s   | cto            | Maryland Prince  | George           | 's                             | Oxo                          | n Hill                        |   |                             |                             |                                |                      |                               | 1X☐ Yes                           | 2   No      |
|              | or 28  | Director       | 10e. Street and Number   |                  |                                |                              |                               | 10f. Zip Code                             |                             |                             | 1                              | 0g. Citizen o        | of What Coul                  | ntry?                             |             |
|              | ath w  | ra             | 1307 Iverson S   |                  |                                |                              |                               | 20745                                     |                             |                             |                                |                      | State                         |                                   |             |
|              | tems<br>ler m  | Funeral        | 11. Marital Status   | Arme             | d Forces?                      |                              | 5. 13. V                      | Vas Decedent of H<br>f Yes, specify Cuba  | lispanic Ori<br>an, Mexicar | gin? (Speci<br>n, Puerto Ri | fy Yes or No-<br>can, etc.)    |                      | lace - Americ<br>lack, White, |                                   |             |
| 3            | be filed within 72 hours after death with the Maryland<br>tal tylgiene.<br>And other than "natural", or Items 23a or 28a-f show<br>event, th. Medical Examiner must be notified at | by F           | 1 Mover Married 2 Man 3 Widowed 4 Divorced   | If Yes           | es 2 🔀<br>s, Give<br>or Dates: | NO                           | 1                             | I□Yes 2127 No                             | Specify:                    |                             |                                | Spec                 | cify: BJ                      | lack                              |             |
| <b>2-003</b> | 2 hou<br>atura   |                | 15. Deceden  |                  |                                |                              |                               | lent's Usual Occup                        |                             |                             | - 54                           | l<br>16b. Kind of    | Business/In                   | dustry                            |             |
| 3            | nin 72<br>in "in<br>Medi   | Completed      | (Specify only higher<br>Elementary/Secondary (0-12)  | st grade comple  | <i>ted)</i><br>ge (1-4or:      | 54)                          | (Give<br>life. L              | kind of work done o<br>OO NOT use retired | during mos<br>d)            | t of working                | " "1                           |                      |                               | -                                 |             |
| 7            | d with<br>giene<br>rrtha<br>th. I  | E O            | 12 years   | Colle            | 98 (1-40)                      |                              | Chi                           | 1d Care                                   | Provi                       | der                         |                                | Priv                 | ate                           |                                   |             |
| land         | be filed value Hygie of other tevent, the  | Be C           | 17. Father's Name (First, Middle,  | Last)            |                                |                              |                               |   | 18. Mothe                   | er's Name (i                | First, Middle, I               | Maiden Surn          | ame)                          |                                   |             |
| <u>a</u>     | 2 should be<br>and Mentai<br>is marked<br>aumatic ev   | To             | Charlie Wheel  | ler              |                                |                              |                               |   |                             | Ruth                        | Burton                         | ı                    |                               |                                   |             |
| Mar          | 2 sho<br>and<br>is ma  |                | 19a. Informant's Name/Relations  |                  |                                |                              |                               | g Address (Street                         |                             |                             |                                |                      |                               | ,                                 |             |
| e)<br>`      | 1 and 2<br>Health<br>tem 27  |                | Yolanda Spence   | er - Dau         | ighte                          |                              |                               | Iverson :                                 |                             |                             |                                |                      |                               |                                   |             |
|              |  |                | 20a. Method of Disposition<br>1 ☐ Burial 2 ☐ Cremation   | 3 □Removal i     | rom State                      | 20b. Pt                      | ace of Dispo<br>emetery, cren | sition (Name of<br>natory or other place  | ce)                         | Dat                         | te                             | 20c. Location        | n - City or T                 | own, State                        |             |
| aitimor      | tnen<br>tant:<br>tant:   |                | 4 Donation 5 Other (S  | Specify)         |                                | Gle                          |                               | Cemetery                                  |                             |                             | , 2008                         |                      |                               |                                   |             |
| a<br>a       | permit. Pages<br>Department of<br>Important: If I<br>any Injury or<br>once.  |                | 21. Signature of Funeral Service   | Licenson         | and                            | 4 1                          | 11                            | . Name and Addre                          |                             |                             |                                |                      |                               |                                   |             |
|              |  |                | 23a Part Foter the dise  | complications t  | 160 0                          | d the death                  | -                             | 01 Benni                                  |                             |                             |                                | -                    | , DC 2                        | Approximate                       | e           |
|              | ul stant   |                | 23a. Pa.11. Enter the dise of the control of the co | only one cause   | on each l                      | ine.                         | - 1                           |   |                             |                             |                                | 304                  | -                             | Interval Bet<br>Onset and I       | ween        |
|              | Physician<br>/Medical  |                | disease or condition<br>resulting in death)  | a                | ev                             | a consequ                    | 0 /                           | Hem                                       | 011                         | hog                         | 2                              |                      |                               |                                   |             |
|              | Examiner   |                |  |                  | LL (or as                      | a consequ                    | i                             | sion                                      |                             |                             |                                |                      |                               |                                   |             |
|              |  | ler            | Sequentially list conditions, if any, leading to immediate   | b                | e to (of ac                    | a consequ                    |                               | 7/07/                                     |                             |                             |                                |                      |                               |                                   |             |
|              | od<br>d<br>ansit   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  | <b>S</b>         | /                              |                              |                               |   |                             |                             |                                |                      |                               |                                   |             |
| Ď.           | an an<br>rial-tr   |                | resulting in death) Last   | Du               | e to (or as                    | a consequ                    | ence of):                     |   |                             |                             |                                |                      |                               |                                   |             |
| 8/6U         | cate be executed<br>physician and<br>the burial-transit  | dical          |  |                  |                                |                              |                               |   |                             |                             |                                |                      |                               |                                   |             |
| 0            | ng ph  | Med            | IF FEMALE:   |                  |                                |                              |                               |   |                             |                             |                                |                      |                               |                                   |             |
| X<br>Q<br>Q  | death certifi<br>e attending I<br>d for use as   | an/l           | 23b. Was decedent pregnant in the past 12 months?  |                  |                                | pf pregnal<br>2 Fetal        |                               | Ectopic pregnancy                         | у                           |                             |                                |                      | Date of deliv<br>Month        |                                   | Year        |
| -<br>-       | w requires that the death certific<br>been signed by the attending p<br>should be detached for use as  | Physician/Me   | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown  |                  | Pregnant a<br>Jnknown          | nt time of de                | eath 5□                       | Other (specify)                           |                             |                             |                                |                      | inoria:                       | Duy                               | roui        |
| 7.           | requires that the<br>een signed by th  |                | Part II. Other significant conditi   | ons contributing | to death b                     | out not resu                 | ıltina in the u               | nderlying cause giv                       | en in Part I                |                             | 23e. Did to                    | hacco use co         | ontribute to                  | the cause of c                    | death?      |
| g,           | signe<br>algne   | d by           | •  |                  |                                |                              | 3                             | , ,                                       |                             |                             | 1 U Y                          | es 2 No              | o 3 □ Pro                     | bably 4 🗖                         | Unknown     |
| Hecords      | v requestions  | etec           |  |                  |                                |                              |                               |   |                             |                             | 24a. Was a                     | D 24                 | Ih Moro aut                   | onau findinas                     | augilahla   |
| Ď            | sician: The law<br>certificate has b<br>irector, page 2 st   | Completed      |  |                  |                                |                              |                               |   |                             |                             | autop                          | med?                 | death?                        | opsy findings<br>ompletion of c   | ause of     |
| VITAI        | in: T  |                | 25. Was case referred to medica  | ıl İ             |                                |                              |                               |   | OF Plan                     | a of Dooth                  | 1☐ Yes<br>Check only or        | 2ENo                 | 1 🗆 Yes                       | 20-No                             |             |
|              | Physician:<br>r this certific<br>ral director,   | o Be           | examiner?  | Hospital:        | 1•☑ Inpati                     | ent 2 🗆 I                    | ER/Outpatien                  | t 3□ DOA Oth                              | ner:                        |                             | e 5 □ Resid                    |                      | Other (Spec                   | if <sub>t</sub> ()                |             |
| 0            | g Phy<br>er thi<br>eral o  | n: To          | 27. Manner of Death  |                  | Date of Inj                    | ury                          | 28b. Time of                  |   |                             |                             | d. Describe h                  |                      |                               | .,,                               |             |
| 0            | ath.<br>r: Aft   | atio           | 1 Natural 5 Pendir<br>2 Accident investi   | ig               | (Month, De                     | ay rear)                     | Injury                        |   | Yes 2                       | No                          |                                |                      |                               |                                   |             |
| DIVISION     | r Atte<br>er deg<br>recto<br>by th   | tific          | 3 Suicide 6 Could 4 Homicide determ  | nined   200.1    | Place of in                    | jury - At ho<br>tc. (Specify | me, farm, str                 | eet, factory, office                      |                             | 28                          | Bf. Location (S<br>City or Tow | treet and Nu         | mber or Rui                   | ral Route Nun                     | nber,       |
| 5            | tal or   | Certification: |  |                  |                                | 10. (Opcoll)                 |                               |   |                             |                             |                                |                      |                               |                                   | San Control |
|              | To the Hospital or Attending Physically hours after death.  To the Funeral Director: After this completely filled in by the funeral di   | edical (       | (Check only 2 Medical  | Examiner: On     | the basis                      | of examinat                  |                               | n occurred at the ti                      |                             |                             |                                |                      |                               |                                   | s)          |
|              | the I  | Med            | one)   |                  | manner st                      | tated.                       |                               | 29c. Licens                               | e number                    |                             |                                | Ind. Date sig        | anod /Month                   | Day Voor                          |             |
| ı            | 7 × × × ×  |                | 29b. Signature and title of certified  |                  | Fin                            | ~                            | $\supset$                     | DAG                                       | 370                         | 66                          | 1                              | n i -                | ned (Month                    | 2008                              |             |
| Δ            | (2)  |                | 20 Name and address of   | who com-1-1      | 001:22 =/                      | don'th //*                   | 020\ /T                       | Brint)                                    | 000                         | 7                           |                                | 1                    | 2)-6                          | 000                               |             |
| K            |  |                | 30. Name and address of person   | 100-1            | /                              |                              | 23a) (Type,                   | ) 6/5                                     | 886                         | Kon                         | Hill                           | Kd H                 | 701,0                         | Konth                             | 11/m        |
|              | Sta  | te             | 31. Date filed (Month, Day, Year)  | 00               |                                | rar's Signat                 |                               |   |                             |                             |                                |                      |                               |                                   |             |
|              | Registr  | ar             | JAN 2 9 2008   | Status           | 10                             | 1                            | all                           |   |                             |                             |                                |                      |                               |                                   |             |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** January 23, 2008 BLanche S. Williams 2:00 am /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Clinton Nursing Home Clinton Prince Georges If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11/19/1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🛱 F Meckenberg, 88 Director 143307707 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County ral", or items 23a or 28a-f show Examiner must be notified at XXYes 2 □ No Directo Fort Washington Maryland Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20744 2805 Lumar Drive Funeral 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2√2 No "natural", or Black ģ 3.☐ Widowed 4 ☐ Divorced er than "natura", the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Mones. Healthcare Nurses Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mag Thomas Richard Smithson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 72a Newark Way Maplewood, New Jersey 07040 Mary James-Edwards 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/29/08 Suitland, Maryland Linciln Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Alexander, S. P 21. Signatur of Funeral Service Lice Alexander S. of Pope.P.A. Pikė/Forėstville, Md. 20747 Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Thin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 No 9☐Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? миет илs certificate has been signed I funeral director, page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hannown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Tyes 2 X No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760, Division or Vital Records, after death filled in by within 24 hours a Hospital

Baltimore, Maryland 21215-0036

completely 10 Registrar

State

and manner stated. 29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

on who completed cause of death (Item 23a) (Type, Print)

STONRE -350

31. Date filed (Month, Day, Year) 2008

29a. Certifier

29b. Signature a

(Check only one)

1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Virginia 25 PM nna Ü /Medical 4a. Facility Name (If not institution, give street and number) b. City, Town, or Location of Death 4c. County of Death Examiner Bay Mallard ambri da Dorchester Center if Under 1 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs
Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 92 1□M 217F Voarl 214-07-8828 Months Days Yrs **Director** July 15, 1915 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at Cambridg 1 Yes 2 No Dorchester Funeral Director 10e. Street and Number 10g. Citizen of What Country? Hia 2/6/3 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Line Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Nitchell Be11 Vongus Hattie James 19a. Informant's Name/Relationship (Type. Print) 19b. Maling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21613 Cambridge, Maryland late | 20c. Looding - City or Town, State Lane Derrick Maryland other Date 20a. Method of Disposition Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/2/08 4 ☐ Donation 5 ☐ Other (Specify) Mt. Pleasant Cometery Salem, Maryland 22. Name and Address of acility
HENRY FUNERAL 21. Signature of Funeral Service Licensee Home, HENRY SIO W Cambridge, MD. 21613 10 Washington St. 23a. Part. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) wore /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last no one Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical attending ph d for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Year Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b irector, page 2 s autopsy pertorroed? Yes 2XINo 1☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: P 2 ER/Outpatient 3 DOA 4 Uursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury I hours after death.

\*\*Cuneral Director: Af all filled in by the fur 1 ☐ Yes 2 ☐ No investigation M 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YRN ST. CAMBRIDGE HOWST Autt 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar amended 4a Certificate of Death 2/1/08 eks Date of Death
 Month 1. Decedent's Name (First, Middle, Last Physician Year 24 2008 4c. County of Death 7:10 PM Ma Tan. /Medical 4a. Facility Name (If not institution, give s street and num Woods 4b. City, Town, or Location of Death **Examiner** Dorchester ambr. da 5. Social Security Number (In vrs. last birthday If Under 1 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F 12-18-6464 46 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10f. Zio Code 10g. Citizen of What Country? 10e Street and Number USA Vob 0 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 Mo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2 ☑ No permit. Pages 1 and 2 should be filed within 72 hours & Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", o any injury or other traumatic event. 9 3 Widowed 4 Divorced Iack Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private WorKer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ೭ MeeKi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cedonia Ave. MD 21206 Redmond Ver bena 1tiMore 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State Cambridge, MD. 30/ 08 4 ☐ Donation 5 ☐ Other (Specify) Cometery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY FUNERAL HOME 510 Washington St. C MD.21613 23a. Part Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** none /Medical Due to (or as a consequence of) Examiner Demente Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 2 Accident hours after death uneral Director; 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RN ST. CAMBRIDGE 50

Registrar

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State

2008

|  |                   | Please Type or Print in BI  |   |  | •                                |   |  |
|--|-------------------|---|---|--|----------------------------------|---|--|
|  |                   | State of Maryland   | / Department of I   |  |                                  | 0000  | 01000  |
|  |                   | 1. Decedent's Name (First, Middle, Last)  | Certificate of  | Dealli                                     | 2. Date of Dea                   | Reg. No.  | 3. Time of Death                                   |
| Physicia<br>/Medic   |                   | John Phillip Weller   | <u> </u>  |  | Month /                          | Day Year 208                                    | 2338PM   |
| Examin   |                   | 4a. Facility Name (If not institution, give street and number)  | 1 0 1 1   | or Location of Death                       |                                  | 4c. County of Dea                               | th   |
| 1 N  |                   | Peninsula Regional Medical Cer<br>5. Social Security Number 9 6. Sex 7. Age (In yrs. las  |   | Ury MID                                    | 8. Date of Birtl                 | Win   | mico<br>thplace (State or Foreign                  |
| Funeral<br>Director  |                   | 149–09–0865 1 M 2 □ F 87  | Yrs. Months Days  | Hours Min.                                 | (Month, Day                      | r, Year) Ci                                     | ountry)  |
| pu   |                   | Usual Residence of Decedent   | Town or Location  |  | 1/30/.                           | 1920   Per                                      | nsylvania  |
| // Anyla   | ō                 |   | clin  |  |                                  |   | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No             |
| r 28a-   | Director          | 10e. Street and Number  | 10f. Zip Code   |  |                                  | 10g. Citizen of What C                          | ountry?  |
| 72 hours after death with the Maryland<br>'natural', or Items 23a or 28a-f show<br>dical Examiner must be notifled at  |                   | 44 Tail of the Fox Drive  | 2181.   |  |                                  | USA   |  |
| er dea<br>Items  | Funeral           | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?   | 13. Was Decedent of<br>If Yes, specify Cub                      | Hispanic Origin? (Spanan, Mexican, Puerto  | ecify Yes or No-<br>Rican, etc.) | . 14. Race - Ame<br>Black, Whi                  |  |
| al", or  | ρ                 | 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 3 ▼ Widowed 4 □ Divorced Year or Dates: Navy                            | 1 ☐ Yes 2 🙀 No  | Specify:                                   |                                  | Specify:  | white  |
| 72 hor   | Completed         | 15. Decedent's Education<br>(Specify only highest grade completed)  | 16a. Decedent's Usual Occu<br>(Give kind of work done           | during most of work                        | ing I                            | 16b. Kind of Business                           | /Industry  |
| within ene.  | d m               | Elementary/Secondary (0-12) College (1-4or 5+)  | life. DO NOT use retire   | ed)  |                                  | Sears   |  |
| Hygid<br>Other<br>ent, th  | Be Co             | 17. Father's Name (First, Middle, Last)   | 00  | 18. Mother's Name                          | (First, Middle,                  | Maiden Surname)                                 |  |
| uld be<br>Menta<br>arked<br>artic ev   | To B              | Charles Weller  |   | Zula Ed                                    | ckenrode                         | <del></del>                                     |  |
| 2 sho<br>and I<br>Is me  |                   | 19a. Informant's Name/Relationship (Type. Print)  | 19b. Mailing Address (Stree                                     |  |                                  | •   |  |
| permit. Pages 1 and 2 should be fled within 72 hours after death with the Maryian Insportant of Health and Mental Hygiene. Insportant: if it meath and Mental Hygiene. and Insportant: if smarked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified at once. |                   | Dennis Weller/son  20a. Method of Disposition 20b. Pla  | 26383 Manch<br>ce of Disposition (Name of                       | ; [  | Salist<br>Date                   | 20c. Location - City or                         |  |
| Pages<br>ent of<br>nt: If it   |                   | 1X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)   | netery, crematory or other pla<br>Peter & Paul                  | 1/30                                       | /08                              | Springfie                                       | ld, PA   |
| rmit.<br>ppartm<br>portal<br>y Inju  |                   | 21. Signestra of Funeral Service King rises   | etery<br>Holloway   |  |                                  |   | Association<br>1804                                |
| 8 2 E 8 9  |                   | MARKET  |   |  |                                  |   |  |
| φ  |                   | 23a/Part1/Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.   | Do not enter the mode of dy                                     | ing, such as cardiac                       | or respiratory ar                | rest,   | Approximate<br>Interval Between<br>Onset and Death |
| Physician<br>/Medical  |                   | Imme Tate Cause (Final disease or condition resulting in death)  a. Due to (or as a conseque                                      | nce of):  |  |                                  |   |  |
| Examiner   |                   | Sequentially list conditions b.   |   |  |                                  |   |  |
| ted sit  | nine              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | nce of):  |  |                                  |   |  |
| be executed<br>cian and<br>ourial-transit  | Examiner          | that initiated events c.  resulting in death) Last C.  Due to (or as a conseque   | nce of):  |  |                                  |   |  |
|  | cal               | d   |   |  |                                  |   |  |
| The law requires that the death certificate the has been signed by the attending physicage 2 should be detached for use as the   | Physician/Medical | IF FEMALE: 23c. If yes, outcome pf pregnant   | N/  |  |                                  |   |  |
| death c  | cian              | 23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ Fetal of 4 ☐ Pregnant at time of dea                               | eath 3 Ectopic pregnand   | су   |                                  | 23d. Date of de<br>Month                        | Day Year   |
| t the c<br>by the  | hysi              | 9 ☐ Unknown   |   |  |                                  |   |  |
| le law requires that the de<br>has been signed by the a<br>ge 2 should be detached   | by                | Part II. Other significant conditions contributing to death but not result  | ng in the underlying cause gi                                   | ven in Part I.                             | _                                | obacco use contribute t                         | _/   |
| requi  | eted              | Transfer fundament  |   |  | 1 0                              | 1000  | robably 4 Minknown                                 |
| he lav<br>e has  | Completed         |   |   |  | 24a. Was<br>autop<br>perfo       | prior to death?                                 | completion of cause of                             |
| ian: T<br>rtificat<br>ttor, pa   | Be C              | 25. Was case referred to medical  |   | 26. Place of Deat                          | 1  Yes<br>h (Check only o        | 2 No 1 Ye.<br>ne)                               | s 2 No   |
| hysic<br>this ce   | To                |   | Voutpatient 3 DOA   |  |                                  | dence 6 □Other (Spe                             | ecify)   |
| Attending Physician: r death. ector: After this certific. by the funeral director,   | ion:              | Natural 5 Pending (Month, Day Year)   | 8b. Time of lnjury 28c. Inju                                    | ıry at<br>ork?<br>]Yes 2 □ No              | 28d. Describe h                  | now injury occurred                             |  |
| Atten<br>r death<br>ector:<br>by the   | ificat            | 3 Suicide 6 Could not be 28e. Place of injury - At hom  | e, farm, street, factory, office                                |  |                                  | Street and Number or F                          | Rural Route Number,                                |
| tal or<br>rs after<br>ral Dir  | Certification:    | 4 ☐ Homicide determined building, etc. (Specify)  |   |  | City or Tou                      | m, state)                                       | 9  |
| To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page  | Medical           | 29a. Certifier (Check only one) Check only 2 ☐ Medical Examiner: On the basis of examination and manner stated.                   | edge, death occurred at the t<br>on and/or investigation, in my | time, date and place, opinion, death occur | and due to the red at the time,  | cause(s) and manner a<br>date and place, and du | is stated.<br>ie to the cause(s)                   |
| ro the<br>vithin 2<br>го the<br>сотре  | Mec               | 29b. Signature and title of certifier   |   | se number                                  |                                  | 29d. Date signed (Mon                           |  |
| AVIVA  |                   | ) yeur  | 06  | 13199.                                     |                                  | 1/26/20   | -8 m   |
| 10,00  |                   | 30. Name and address of person who completed cause of death (Item 2   |   | A O  | 445 2                            | .0-4  |  |
| Sta  | te                | YOGE SH VOHRA GIY EASTERN  31. Date filed (Month, Day, Year)  JAN 2 9 2008  32. Regularar's Signatu                               | SHOKE UK., S.   | HLUBURY                                    | MD, Z                            | -1809   |  |
| Registr  |                   | JAN 2 9 2008  | de forto  |  |                                  | ·   |  |
| HMH 17 Rev 1/20  | 001               |   |   |  |                                  |   |  |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 26 2008 6:10 Katharine Aylwin Winter January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Calvert Manor Healthcare Center Rising Sun Ceci1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 □ M 2 🛛 F March 5, 1915 Director 220-30-7180 92 New York Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a, State 10d. inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1881 Telegraph Road 21911 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No if Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 X Never Married 2 Married Specify: White 1 ☐ Yes 2 🔯 No by Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than " Elementary/Secondary (0-12) College (1-4or 5+) 5+ Librarian University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William West Winter Mary Major 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Winter/Nephew 615 Kensington Drive, Lincoln University, PA 19352 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. John Cemetery 2-2-2008 Brooklyn, New York 21. Signatura 22. Name and Address of Facility T. Foard Funeral Home, P.A. S. Queen Street, Rising Sun, 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SKNOWING / disease or condition resulting in death) 1 week /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 20 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2N No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: Amursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined

death certificate be executed and burial-P.O. Box 68760, physician the as attending properties of the second signed by the a Division or Vital Records, been si should I has certificate Hospital or Attending Physician: this within 24 hours after death

To the Funeral Director:
completely filled in by the

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

r 28a-f show notified at

6 6

"natural", or Items 23a adical Examiner must b

Medical

Is marked other

10+IVA

To the h

Registrar

101 COLOWIAL 31. Date filed (Month, Day, Year)

29a. Certifier

29b. Signature and title of certifier

Suite A Begistrar's Signature JAN 3 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Medical

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|  | 1 - For State Registrar   | State o   | f Marylan  |  | ırtment<br><i>tificate</i>                           |                             | ealth and M<br>Death                                 |  | iene<br>eg. No. 2 | 008  | 04068  |  |  |  |
|--|---|---|--|--|--|-----------------------------|--|--|-------------------|--|--|--|--|--|
| Physician<br>/Medical  | 1. Decedent's Name (First, Middle, L<br>Treatice Lu   |   | illaman  |  |  |                             |  | 2. Date of Dea<br>Month<br>January       | Day               | Year<br>2008                                       | 3. Time of Death 12:20 p M                               |  |  |  |
| Examiner   | 4a. Facility Name (If not institution, g. Carroll Hospice   |   |  |  |  |                             | Location of Death                                    |  | _                 | unty of Death Carrol                               | 1  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number 6. 252–36–3436  | Sex<br>1□M 2 <b>X</b> F                                     | 7. Age (In yrs.<br>87  | last birthday)<br>Yrs.                                 | If Under 1<br>Months                                 | Year<br>Days                | If Under 24 Hrs.<br>Hours Min.                       | 8. Date of Birth (Month, Day             | Year)<br>1920     | 9. Birthp<br>Cour<br>Penn                          | olace (State or Foreign<br>ntry)<br>Isylvania            |  |  |  |
| a-f show   | Usual Residence of Decedent 10a. State 10b. County  Maryland Carro.   | 11  | 10c. Cit   | y, Town or Lo  | cation   | 1                           | Westmins   | ter                                      |                   | 1  | 0d. Inside City Limits 1 ☐ Yes 2 No                      |  |  |  |
| a or 28 at be not  | 10e. Street and Number<br>507 High Acre Dr  | ive   |  |  | 10f. Zip (   | Code                        | 21157  | 1  | 0g. Citizer       | of What Cour                                       | ntry?  |  |  |  |
| be filed within 72 hours after death with the Maryland that Hygiene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Be Completed by Funeral Director |   | 12. Was Dec<br>Armed Fo<br>1  Yes<br>If Yes, G<br>Year or D | 2 No<br>ve   | 1  | Vas Decede<br>f Yes, speci<br>□ Yes 2                |                             | spanic Origin? (Sp<br>n, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)         |                   | Race - Americ<br>Black, White,<br>pecify: whi      | etc.   |  |  |  |
| ed within 72 hourygiene. Per than "natural t, the Medical Ex   |   | Education   |  | (Give<br>life. L                                       | lent's Usual<br>kind of work<br>OO NOT use<br>Carian | k done d<br>e retired)      | uring most of work                                   | ting                                     |                   | of Business/In                                     | dustry   |  |  |  |
| be filed<br>ntal Hygi<br>od other<br>event, t  | 17. Father's Name (First, Middle, Las   | st)   |  | 10101  | arian  |                             | 18. Mother's Name                                    | e (First, Middle, M. Mille               | Maiden Su         |  |  |  |  |  |
| ges 1 and 2 should b tt of Health and Ments If item 27 is marked or other traumatic e  | 19a. Informant's Name/Relationship<br>Rebecca S. Fishe  |   | hter   | 19b. Mailin<br>23 N                                    | g Address (  | (Street a                   | nd Number or Rui<br>Street, W                        | ral Route Numbe<br>Vestmins              | r, City or To     | own, State, Zip<br>MD 211                          | Code)  |  |  |  |
| permit. Pages 1 s Department of He Important: If item any Injury or oth  | 20a. Method of Disposition  1   ■ Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec  | cify)   | State 20b. F   | Place of Disponentery, cremetery, cremetery, cremetery | sition (Name<br>natory or oth<br>Vall                | e of<br>her place<br>.ey (  | e)<br>Cem. 2/2/                                      | <sup>/</sup> 2008                        |                   | ion - City or To<br>nier, I                        |  |  |  |  |
| Depart<br>Import<br>any Inj<br>once.   | 21. Signature of Funeral Service Lic  | May   | les  | 22   | Name and Wil   | Addres                      | s of Facility My<br>Street,                          | ers-Durl<br>Westmin                      | oraw<br>ster,     | Funera<br>MD 21                                    | al Home<br>157   |  |  |  |
| hysician<br>/Medical   | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of): |   |  |  |  |                             |  |  |                   |  |  |  |  |  |
| Examiner   | Sequentially list conditions, if a p, hading to in mediat cause. Enter Underlying Cause (Disease or injury that initiated events  | b. Due to   | or as a consequence of the conse | er Benuten   |  |                             |  |  |                   |  | Imo  |  |  |  |
| cate be executed physician and s the burial-transit  | resulting in death) Last  | c. Due to   | (or as a conseq  |  |  |                             |  |  |                   |  | Come   |  |  |  |
| ng physicia<br>as the bur  | IF FEMALE:  | d   | week.  | mille  | X IM   | De                          | Jennu  |  |                   |  | dun  |  |  |  |
| w requires that the death cerms been signed by the attending I should be detached for use as leted by Physician/Me   | 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  | 1□Live  | itcome pf pregna<br>birth 2 □ Feta<br>nant at time of c<br>nown  | al death 3 □   | Ectopic pre<br>Other (spe                            |                             |  |  | 230               | d. Date of deliv<br>Month                          | ery<br>Day Year  |  |  |  |
| een signed by nould be deta  |   | contributing to c   | leath but not res  | ulting in the ur                                       | nderlying ca   | use give                    | n in Part I.   | 23e. Did to                              |                   |  | he cause of death?<br>bably 4 □Unknow                    |  |  |  |
| ate has  |   |   |  |  |  |                             |  | 24a. Was a<br>autop<br>perfor<br>1∐ Yes  | med?              | 24b. Were auto<br>prior to co<br>death?<br>1 ☐ Yes | opsy findings availabl<br>impletion of cause of<br>2□ No |  |  |  |
| his certiful director  | examiner?   | Hospital: 1   | Inpatient 2  | ER/Outpatien   | t 3 DO   | A Othe                      | 26. Place of Deat<br>r: 4 ☐ Nursing Ho               | th <i>(Check only or</i><br>ome 5□ Resid | •                 | Other (Speci                                       | m Dare 14  |  |  |  |
| or: After the funera   | 27. Manner of Death  Natural 5 Pending  Decident investigati  | on  | of Injury<br>oth, Day Year)  | 28b. Time of<br>Injury                                 | M 28   | 3c. Injury<br>Work<br>1 □ \ | at<br>?<br>∕es 2 □ No                                | 28d. Describe h                          | ow injury o       | occurred   |  |  |  |  |
| To the hospital of Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be C             |   | d 28e. Plac<br>build  | e of injury - At he<br>ling, etc. (Specia  | (y)  | 1  |                             | and date and the                                     | City or Tow                              | n, State)         |  | al Route Number,   |  |  |  |
| o the Hosp<br>ithin 24 hou<br>the Fune<br>ompletely fi   | (Check only 2 Medical Ex  | aminer: On the  | e best of my kno<br>pasis of examina<br>oner stated.   | wiedge, death  | estigation,  | in my op                    | ne, date and place,<br>pinion, death occu            | rred at the time,                        | date and p        | ace, and due t                                     | to the cause(s)  |  |  |  |
|  | 29b. Signature and title of certifier   | X   | 4  | 2  |  | License<br>N 3              | 7aua   | 4  |                   | signed (Month,                                     | . A  |  |  |  |
| MJZ  | 30. Name and address of person when   | completed cau   | so of death (Iter  | n 28a) (Type,  |  | h                           | 4  | CI                                       | _ 11-             | 2011   | M2003  |  |  |  |
| State<br>Registrar   | 31. Date filed (Month, Day, Year)   | 32.1  | Regular's Signa  | ature  | - 0  | ٠٠٠                         | we ve  | - au                                     |                   | -Ci w  |  |  |  |  |

Registrar

|  |  |                  | for<br>State<br>Registrar  | State o                                 | f Marylan                              |                        | artment of<br>tificate o             |                      |                        | _                               | giene ,<br>Reg. No. (                     | 2008  | 3 0           | 4069           |  |
|--|--|------------------|--|---|--|------------------------|--------------------------------------|----------------------|------------------------|---------------------------------|---|---|---------------|----------------|--|
| 1. Decedent's Name (First, Middle, Last)                   |  |                  |  |   |  |                        |                                      |                      | 2. Date of De<br>Month | ath<br>Day                      | Year                                      | 3. Tim                                      | e of Death    |                |  |
|  | Physician /Medical Virginia Elinore Adamson  |                  |  |   |  |                        |                                      |                      |                        | 2008 1:30 AM                    |   |   |               |                |  |
| 1  | Examir   |                  | 4a. Facility Name (If not institution,   | give street and nur                     | nber)                                  |                        | 4b. City, Town                       | , or Location        | of Death               |                                 |   | ounty of Dea                                |               |                |  |
|  |  |                  | Rockville Nurs   | ing Home                                |  |                        |                                      | Roc                  | kvill                  | e                               | М   | ontgom                                      | erv           |                |  |
|  | Funeral  |                  | 5. Social Security Number 6  | 6. Sex                                  | 7. Age (In yrs.                        | last birthday)         | If Under 1 Yes                       | r If Unde            | r 24 Hrs.<br>Min.      | 8. Date of Bir<br>(Month, Da    | th  | 9. Birl                                     | thplace (Sta  | ite or Foreign |  |
|  | Director   |                  | 234-52-9681  | 1 □ M 2 🔀 F                             | 78                                     | Yrs.                   | Months Day                           | S Hours              | IVIIII.                |                                 | 0/192                                     |   | ouintry) .    |                |  |
| vision or Vital Records, P.O. Box 68760,                   | TI   |                  | Usual Residence of Decedent  |   |  |                        |                                      |                      |                        | 12/3                            | 0/132                                     | 2 111                                       |               |                |  |
|  | ylund<br>yow   |                  | 10a. State 10b. County   |   | 10c. City                              | y, Town or Lo          | cation                               |                      |                        |                                 |   |   | 10d. Insid    | e City Limits  |  |
|  | Mar<br>fied  | to               | MD Monto   | omery                                   | Ro                                     | ckvill                 | e                                    |                      |                        |                                 |   |   | 1 🗆           | res 2 No       |  |
|  | the 288  | Funeral Director | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?   |   |  |                        |                                      |                      |                        |                                 |   |   |               |                |  |
|  | Mitt<br>Sa o   |                  | 13302 Turkey Bi  | ranch Bar                               | lezzorz                                |                        | 2085                                 | 2_                   |                        |                                 | IIm i                                     | T-3 CT                                      |               |                |  |
|  | ns 2<br>mus  | era              | 11. Marital Status   |   | dent Ever in U.                        | S. 13. V               | Vas Decedent of<br>f Yes, specify Co |                      | rigin? (Spe            | ecify Yes or No                 |   | ted St<br>. Race - Ame                      |               | ١,             |  |
|  | Iten<br>Iner   | F                | 1 ☐ Never Married 2 Marrie   | Armed Fo<br>d 1 ☐ Yes                   |  |                        |                                      |                      | an, Puerto             | Rican, etc.)                    |   | Black, Whit                                 | e, etc.       |                |  |
| 36   | Is at  | b                | 3 ☐ Widowed 4 ☐ Divorced   | If Yes, Giv<br>Year or D                | re ·                                   |                        | I□Yes 2⊠N                            | o Specify            | <b>/</b> :             |                                 | S   | pecify:                                     | nite          |                |  |
| Ö  | hou<br>ttura   | ed               | 15. Decedent's   | Education                               |  | 16a. Deced             | lent's Usual Occ                     | upation              |                        |                                 | 16b. Kind                                 | of Business                                 |               |                |  |
| 15   | in 72  | olet             | (Specify only highest  | grade completed)                        | 4. 7.                                  | (Give<br>life. L       | kind of work don<br>DO NOT use reti  | ne during mo<br>red) | st of worki            | ing                             | Edu                                       | cation                                      |               |                |  |
| 12   | within<br>lene.<br>than "  | To Be Completed  | Elementary/Secondary (0-12)  | College (1                              | -40r 5+)                               | Pro-                   | School                               | Teache               | ar.                    |                                 |   |   |               |                |  |
| 2  | e filed within al Hygiene. I other than " vent, the M  |                  | 17. Father's Name (First, Middle, L  | ast)                                    |  | *10-                   | DCIIOOI                              |                      |                        | (First, Middle,                 | , Maiden Si                               | urname)                                     |               |                |  |
| au   | ould be<br>Mental<br>larked o  |                  | Golden Gordon W  |   |  |                        |                                      | Wo                   | lma s                  | Ct o who are                    |   |   |               |                |  |
| or Vital Records, P.O. Box 68760, Battimore, Maryland 2121 | s 1 and 2 should be filed within 72 hours after death with the Marylu'n f Heatht and Mental Hygiene. If Heatht and Mental Hygiene tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the M-dical Examiner must be notified at  |                  | 19a. Informant's Name/Relationshi  |   |  | 10h Mailin             | g Address (Stre                      | 1                    |                        | Starkey                         | or City or I                              | Town State                                  | Zin Codo)     |                |  |
| Mai  | h an<br>h an<br>7 is r<br>traur  |                  | Albert George Ac   |   | hand                                   |                        |                                      |                      |                        |                                 |   |   | ,             |                |  |
| or Vital Records, P.O. Box 68760,                          | ss 1 and 2<br>of Health<br>item 27 is<br>rother tra  |                  |  | Jamson/ Rus                             |  |                        | 02 Turke<br>sition (Name of          | y Bra                |                        | arkway                          |   | ville,<br>tion - City or                    |               |                |  |
| 0  | ges it of H  |                  | 20a. Method of Disposition<br>1 ☐ Burial 2 【Cremation :  | 3 □Removal from                         | 1 0                                    | emetery, cren          | natory or other p                    | lace)                |                        | Feb 12                          | 200. 2006                                 | mon - City of                               | TOWII, State  | 3              |  |
| Ξ.   | nit. Pagartmen<br>ortant:<br>injury  |                  | 4 □ Donation 5 □ Other (Spe  | ecify)                                  | Cl                                     | nesapea                | ake Crem                             | atory                |                        | 2008                            | Belt                                      | sville                                      | , Mary        | land           |  |
| a  | permit. Page<br>Department of<br>Important: If<br>any injury or  |                  | 21. Signature of Funeral Service Li  | ice)ised                                | M0038                                  | 4                      | . Name and Add                       |                      | ,                      |                                 |   |   |               |                |  |
| m  | Dep<br>Imp<br>any  |                  | Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-   |   |  |                        |                                      |                      |                        |                                 |   |   |               |                |  |
|  | -  |                  | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between |   |  |                        |                                      |                      |                        |                                 |   |   |               |                |  |
|  | Physician<br>/Medical<br>Examiner  |                  | Immediate Cause (Final   | C                                       | 0 -0 b ~ 1                             | 1100                   | 4.100 1                              | Acaid.               | -A L                   |                                 |   |   | Onset a       | nd Death       |  |
|  |  |                  | disease or condition resulting in death)   | a. Due to                               | or as a consequ                        |                        | ular 1                               | 4CCI C               | ay                     |                                 |   |   | 100           | reek           |  |
|  |  |                  | 1  | Н                                       | 11000                                  | 24 51/20               |                                      |                      |                        |                                 |   |   | 1100          | 100            |  |
|  |  | e.               | Sequentially list conditions, if any, leading to immediate   | b. Due to (                             | or as a consequ                        | uence of):             | 1                                    |                      |                        |                                 |   |   | 4 00          | 3              |  |
|  | ted<br>nsit  | Ë                | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events   |   |  |                        |                                      |                      |                        |                                 |   |   |               |                |  |
| _  | and<br>I-trai  | Examin           | that initiated events<br>resulting in death) Last  | c                                       | or as a consequ                        | uence of):             |                                      |                      |                        |                                 |   |   |               |                |  |
| 90,  | cian<br>cian   |                  |  |   |  |                        |                                      |                      |                        |                                 |   |   |               |                |  |
| 8760   | cate be executed<br>physician and<br>the burial-transit  | dical            | d  |   |  |                        |                                      |                      |                        |                                 |   |   |               |                |  |
|  |  | Me               | IF FEMALE:   |   |  |                        |                                      |                      |                        |                                 |   |   |               |                |  |
| ô  | leath certifi<br>attending<br>I for use as   | an/              | 23b. Was decedent pregnant in the past 12 months?  | 23c. If yes, out<br>1☐Live b            | come pf pregna<br>irth 2□Feta          | incy<br>Ideath 3□      | Ectopic pregnar                      | псу                  |                        |                                 | 23  | <ul> <li>d. Date of de<br/>Month</li> </ul> | livery<br>Day | Year           |  |
| Ξ.   | dea<br>ne at<br>ed fo  | sici             | 1 ☐ Yes 2 ☑ No   | 4□Pregn<br>9□Unkno                      | ant at time of d                       | eath 5□                | Other (specify)                      |                      |                        |                                 |   | WOTH  | Day           | I bai          |  |
| Ö  | at the de<br>by the a<br>tached  | Physician/Me     | 9 Unknown  |   |  |                        |                                      |                      |                        |                                 |   |   |               |                |  |
| ecords, P.   | s that<br>med b<br>e deta  | Completed by P   | Faith. Other significant contributing to death but resolving states given in Faith.  |   |  |                        |                                      |                      |                        |                                 |   | e to the cause of death?                    |               |                |  |
|  | w requires<br>been signe<br>should be  |                  | Kenal Carcinoma, Hyperholidemia  |   |  |                        |                                      |                      |                        | Yes 2 No 3 Probably 4 Unknown   |   |   |               |                |  |
|  | w re-  |                  | 24a. Wa  |   |  |                        |                                      |                      |                        | 24a. Was                        | s an 24b. Were autopsy findings available |   |               | ngs available  |  |
| æ  | The lav  | m                |  |   |  |                        |                                      |                      |                        | auto                            | psy<br>ormed?<br>2 2 No                   | death?                                      | completion    | of cause of    |  |
| <u>a</u>   | ilcian: Th<br>certificate<br>rector, pag   |                  |  |   |  |                        |                                      |                      |                        |                                 | -   | 1 ☐ Yes                                     | 2 □ No        |                |  |
| Vital Re   | sician:<br>certific<br>rector,   | Be               | 25. Was case referred to medical examiner?   | The sale                                |  |                        |                                      |                      |                        |                                 |   |   |               |                |  |
| 5  | this al di   | ျဉ               | 1 ☐ Yes 2 XNo  |   | · · · · · · · · · · · · · · · · · · ·  | ER/Outpatien           | 1 3 DOA                              | 4 200                |                        | me 5 Resi                       | -   |   | cify)         |                |  |
|  |  | ü.               | 27. Manner of Death  1   Matural 5 □ Pending   |   | h, Day Year)                           | 28b. Time of<br>Injury | 28c. In                              |                      |                        | 28d. Describe                   | now injury (                              | occurred                                    |               |                |  |
| <u>Si.</u>   | vttendi<br>death.<br>ctor: A<br>y the fu   | sati             | 2 Accident investigation 3 Suicide 6 Could not be  |   |  |                        |                                      |                      | _INO                   |                                 |   |   |               |                |  |
| ≅  | er de  | Įį               | 3 ☐ Suicide 6 ☐ Could no<br>4 ☐ Homicide determin  | 200. Flace                              | of injury - At ho<br>ng, etc. (Specify | me, farm, stre         | et, factory, offic                   | е                    | 1                      | 28f. Location (3<br>City or Tox | Street and i<br>wn, State)                | Number or Ri                                | ural Route I  | Number,        |  |
|  | tal c<br>rs aft<br>al Di<br>ed in  | Certification:   |  |   |  |                        |                                      |                      |                        |                                 |   |   |               |                |  |
|  | hound<br>hound<br>ly fill  |                  |  | Physician: To the<br>xaminer: On the ba |  |                        |                                      |                      |                        |                                 |   |   |               | en/e)          |  |
|  | To the Hospital or Attenc<br>within 24 hours after death<br>To the Funeral Director:<br>completely filled in by the  | edical           | one)   | and manr                                |  |                        | . Congation, III III                 | , opinion, de        | ,au, oouull            | a at the time,                  | account p                                 | , and dut                                   | uio cau       |                |  |
|  | To the To the Complete Complet | Me               | 29b. Signature and title of certifler 29c. License number  |   |  |                        |                                      |                      |                        |                                 | 29d. Date                                 | signed (Mont                                | th, Day, Yea  | r)             |  |
|  |  |                  | Prima Mas Dallakar North MP 041794   |   |  |                        |                                      |                      |                        | February 11, 2008               |   |   |               |                |  |
| ,  | Y  |                  | 30 Name and address of person w  | ho completed caus                       | 9                                      |                        | Print)                               |                      |                        |                                 |   |   |               |                |  |
| 4  | 7  |                  | Priscilla Callahan   |   |  | 1 RUSS                 |                                      | nue                  | Gair                   | Hersbu                          | va n                                      | NP ZO                                       | 0879          |                |  |
|  | Sta  | te.              | 31. Date filed (Month, Day, Year)  |   | egistrar's Signa                       |                        | AP -                                 |                      | J - 51                 | 3                               | 11  |   |               |                |  |
|  | Registr  |                  | FFR 1 3  | 2008                                    | PARIS &                                | The second             | Bar Sin                              |                      |                        |                                 |   |   |               |                |  |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? amend #5 Per FH G876 2/22/08 rtiffcate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 03:43 AM AKISANYA JASON FEBRUARY 09 2008 /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death **Examiner** JOHNS HOPKINS HOSPITAL BALTIMORE CITY n/a If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Sep 1, 1988 9. Birthplace (State or Foreign Country) Rhode Island 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**№** M 2□ F <del>035</del>-58-1429 19 Vrs Director Usuat Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "naturel", or Items 23s or 28s-f ehow 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits sust be notified at Abingdon MD Harford 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? United States 21009 114 Waldon Road Apt F Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian traumatic event, the Madical Examiner: 11 Marital Status Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Etementary/Secondary (0-12) College (1-4or 5+) Automobile salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dillise Gonzonie Olugbenga Akisanya 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dillise Green-Mother 3729 Washington Ave., Baltimore, MD 21244 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 'n ortant: If Woodlawn Cemetery 2.15.08 njury Baltimore, MD Donation 5 Other (Specify) aturn of Funeral Service Li 22. Name and Address of Facility John L. Williams Funeral Dir Depar Impor any in ht. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. 1701 Laurens St Baltimore, MD 21217 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** TRANSPLANT REJECTION IWEEK disease or condition /Medical resulting in death) **Examiner** 057 CARDIUMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) P.O. Box 68760, the attending physicien Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by should be 2No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an certificate has page 2 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 npatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pendina Injury 1 ☐ Yes 2 ☐ No death. thours after death investigation the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Wed in by determined 4 Homicide Hospitel within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d Date sinned (Month, Day, Year) 29b. Signature and title of certifier LES-000 FEBRUARY, 09, 2008 MEDICAL DUCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAVITA SHAPMA, STREET, BALTIMORE MARYLAND 21282 600 NORTH WOLFE egistrar's Signatur 31. Date filed (Month; Day, Year) 32. State 2008 3 Registrar

|  |  | Please  | Type or Prin   | nt in Bla       | ck Ind  | delible Ink  | . Ensure  | All Copies                        | s Are  | Legible.                                |  |  |  |
|--|--|---|--|-----------------|---|--|---|-----------------------------------|--|---|--|--|--|
|  |  | For   | State of Ma  | aryland /       |   |  |   | Mental Hy                         | /gien  | е                                       |  |  |  |
|  |  | State<br>Registrar  |  |                 | Cer   | tificate of  | Death   |                                   | Reg. N   | .2008                                   | 0407   |  |  |
| Physici<br>/Medic  |  | 1. Decedent's Name (First, Middle, Last)  Elmer Charle  |  |                 |   | · A bels   |   |                                   | 2. Date of Death Month Day K Year Feldway 4 9008 5. PM |   |  |  |  |
| Examir   |  | 4a. Facility Name (If not institution, ga   |  |                 |   | 4b. City, Town, o  | or Location of Dea                                | ath                               | (4   | c. County of Deal                       | th   |  |  |
| T.   |  | Good Samaritan I  |  | e (In yrs. last | In inthesion of   | Baltime<br>If Under 1 Year   |   | s. 8. Date of B                   | 17   | n/a                                     |  |  |  |
| Funeral<br>Director  |  | 212-01-3977   | Yrs.   | Months Days     | Hours Mir   | ay, Year   | 9. Birthplace (State or Foreign Country)  1917 MD |                                   |  |   |  |  |  |
| and w  |  | Usual Residence of Decedent  10a. State 10b. County   | own or Lo  | cation          | -   |  | 10d. Inside City Limits                           |                                   |  |   |  |  |  |
| Mary<br>I-f sho<br>fied a  | tor  | MD Baltimo  | Ba   | ore             |   |  | 1 □Yes 2  |                                   |  |   |  |  |  |
| th the or 288  | Funeral Director   | 10e. Street and Number  | Baltimore 10f. Zip Code  |                 |   |  |   | 10g. C                            | itizen of What Co                                      | ountry?                                 |  |  |  |
| ath wi   | ral  | 1601 E. Belvedere   |  |                 |   |  |   | USA                               |  |   |  |  |  |
| er de  | nue  | <ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>  | Ever in U.S.   | 13. V           | Vas Decedent of F<br>f Yes, specify Cub   | (Specify Yes or Nerto Rican, etc.)   | lo-   | 14. Race - Ame<br>Black, Whit     |  |   |  |  |  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event; the Medical Examiner must be notified at once.  | þ  | 3 Widowed 4 Divorced  | tv∑Yes 2 ☐ f<br>If Yes, Give<br>Year or Dates:                         | 10              | _   1   | I□Yes 2√√ No   | Specify:  |                                   |  | Specify: W                              | hite   |  |  |
| n 72 ho<br>"natu<br>edleal   | Completed  | 15. Decedent's Education<br>(Specify only highest grade completed)  |  |                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) |  |   |                                   |  | 16b. Kind of Business/Industry          |  |  |  |
| within<br>iene.<br>• than<br>the M   | dmo  | Elementary/Secondary (0-12)   | College (1-4or 5   | i+)             |   | lesman   | <i>u</i> )  |                                   |  | Retail                                  |  |  |  |
| al Hyg<br>other  | Be C   | 17. Father's Name (First, Middle, Las   |  | Lebilan         | 18. Mother's N  | ame (First, Middl  | dle, Maiden Surname)                              |                                   |  |   |  |  |  |
| Menta<br>Menta<br>arked<br>aric e  | To E   | Elmer Charles   |  |                 | Adele   | Schmidt  | t   |                                   |  |   |  |  |  |
| 12 sho<br>h and<br>7 is m<br>traum   |  | 19a. Informant's Name/Relationship  |  | 1               |   | g Address (Street  |   |                                   |  |   | Zip Code)                                    |  |  |
| 1 and<br>Healt<br>em 2   |  | Mrs. Cindy Hilber 20a. Method of Disposition  | rt-Rayme/da  | 20b. Place      | of Dispo  | sition (Name of  |   | Date                              | _  | 21111<br>Location - City or             | Town. State                                  |  |  |
| Pages<br>ent of<br>nt: If II   |  | 1 ☐ Bunal 2 ☐ Cremation 3<br>4 ☐ Donation 5 ☐ Other (Spec   |  |                 |   | natory or other pla<br>ematory   | - 1   | 08                                |  | onsville                                |  |  |  |
| partm<br>portal<br>y Inju  |  | 21. Signature of Funeral Service Lic  | **   | / Hett          | 22  | . Name and Addre   | ess of Facility                                   |                                   |  |   |  |  |  |
| <b>8</b> 2 <b>E 6</b>  |  |   | nmon   |                 |   | mmon Fun<br>W. Pado  |   |                                   |  | m v 2 1 0 9 3                           | T  |  |  |
| Physician<br>/Medical  |  | 23a. Part1. Enter the disease, or co-<br>shock, or heart failure. List onl<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)   | mplications that caused<br>y one cause on each lin<br>a. Due to (or as | ro Ve           | 23 C  | er the mode of dyi   |   | ec or respiratory                 | /  | )—                                      | Approximate Interval Between Onset and Death |  |  |
| eath certificate be executed attending physician and for use as the burial-transit   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of): |   |  |                 |   |  |   |                                   | Zetterfr   |   |  |  |  |
| ficate be<br>physicia<br>s the bu  | dical  | d   |  |                 |   |  |   |                                   |  |   |  |  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the but  | Physician/Medical  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  1 □ Ves 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown   |  |                 |   |  |   |                                   |  | 23d. Date of delivery<br>Month Day Year |  |  |  |
| w requires that the d<br>been signed by the<br>should be detached  | þ  | Part II. Other significant conditions   | nderlying cause giv  | ven in Part I.  |   | Did tobacco use contribute to the cause of death?<br>I □ Yes 2 □ No 3 □ Probably 4 ☑ Unknown |   |                                   |  |   |  |  |  |
| rsiclan: The law re<br>s certificate has bee<br>lirector, page 2 sho   | Completed  |   |  |                 | *   |  |   | 24a. Wa<br>- aut<br>per<br>1□ Yes | opsy<br>formed?  | prior to death?                         |  |  |  |
| clan:  | Be   | 25. Was case referred to medical examiner? 26. Place of Death (Check only one)  |  |                 |   |  |   |                                   |  |   |  |  |  |
| Physic<br>this cral dir  | 2  | 1 ☐ Yes → No  |  |                 |   |  |   |                                   |  |   |  |  |  |
| dlng<br>h.<br>: After<br>funer   | tion   | Natural 5 ☐ Pending  2 ☐ Accident investigation   | f 28c. Injury at Work?  M 1  |                 |   | escribe how injury occurred  |   |                                   |  |   |  |  |  |
| al or Atten<br>after deat<br>I Director<br>d in by the   | Certification:   | 3 Suicide 6 Could not determine   | be 290 Place of init   |                 | , farm, stre  | eet, factory, office   |   | 28f. Location<br>City or T        |  |   | dural Route Number,                          |  |  |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.  | edical C   | 29a. Certifier  (Chack only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                 |   |  |   |                                   |  |   |  |  |  |
| To the to the total communication of the total c | M  | 29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  February 5 2006  30. Namer and address of person who completed cause of heath (Item 23a) (Plype, Print)  Solver Burner  29d. Date signed (Month, Day, Year)  February 5 2006  February 5 2006  |  |                 |   |  |   |                                   |  |   |  |  |  |
| 8  |  | 30. Name and address of person wh   | aven.  | BLU             | al-   | Print) Bal   | lino  | 20.                               | Ho   | 1-2/                                    | 1239.  |  |  |
| Sta<br>Registr   |  | 31. Date filed (Month, Day, Year)   | 32 Registr   | ar's Signature  | A SE  | sale)  |   |                                   |  |   | ·  |  |  |
| MH 17 Pay 1/9  | 001  |   | V-   |                 |   |  |   |                                   |  |   |  |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Quinta Augustine February 2008 11:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Manor Care - Potomac Potomac Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🕅 F 042-14-8764 89 Director July 3, 1918 Italy Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland 1X Yes 2 □ No Montgomery Rockville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 419 Green Pasture Drive 20852 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 Elementary/Secondary (0-12) College (1-4or 5+) 8 Seamstress Retail permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If Item 27 is marked other I any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Giuseppi Mosca Maria G. Marucci ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley G. Augustine/Daughter 419 Green Pasture Drive, Rockville, Maryland 20852 20b. Place of Disposition (Name of Gate of Heaven Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State February 12 Silver Spring, 4 □ Donation 5 □ Other (Specify) Cemetery 2008 Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, Maryland 20850 M001360 John Sin 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rever Aorthic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed Due to (or as a consequence of): burial-P.O. Box 68760, physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Peripheral vascular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Kinknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an certificate has page 1∐ Yes 2 340 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director; After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00054516 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Avenue suit 1-17 silverspring 40200 Sunida

State

Registrar

Bhogavin.

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31. Date filed (Month, Day, Year)

FEB

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Albert Louis 12:20 PM 12 February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keswick Multi Care Center Baltimore N/A 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 ☐ F Months 219-01-7890 Director 88 June 17, 1919 Mary land Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 1 Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3900 N. Charles Street #1206 Funeral 21218 USA Pages 1 and 2 should be filed within 72 hours after death onent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WWII 10. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. Specify: White ۾ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Retailer and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Berney 60015 Gretchen ည Hochschild 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 is any Injury or other tra Berney 1 Daughter Buttimore, MD 2/2/8 4000 N. Charles St. # 703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Gifts Registry February 12, 2008 Hanover, MD 22. Name and Address of Facility Anatomy Gifts Registry
7522 Connelley Drive Suite P. Hanover MD 21076 21. Signature of Funeral/Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, at complications that aused the death. Do not enter the mode of dying, such as lardiac or respiratory arrest, shock, or heart failure. List only make a days on each line. mmediate Cause (Final **Physician** disease or condition resulting in death) car de omy of N LOVS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pulmenary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has by page 2 s 24a. Was an autopsy performed? Yes 2 No 1∐ Yes or Attending Physician: this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ၉ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Director: After the in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 2 Accident М 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L the Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 58303 29d, Date signed (Month, Day, Year) (ehrvary 12 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST Tonson up 2 1204 J-CHAMINS w 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

3

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|               |   |                | For<br>State<br>Registrar  |                         | State of Ivia  | arylario                     |                            | tificate of l   |                              |                                    | giene<br>Reg. No.2          | 300  | 04074   |
|---------------|---|----------------|--|-------------------------|--|------------------------------|----------------------------|---|------------------------------|------------------------------------|-----------------------------|--|---|
|               | Physicia  | an             | Decedent's Name (Fire  |                         | )  |                              |                            |   |                              | 2. Date of De<br>Month             | Day                         | Year   | 3. Time of Death 1:30 AM M                              |
|               | /Medic  | al             | John Josep 4a. Facility Name (If not   |                         | street and number)   |                              |                            | 4b. City, Town, or  | Location of Dea              | Febru                              |                             | , 2008   | 1.50 12.191   |
| ļ             | Examin  | er             | 11419 Oak  |                         |  |                              |                            |   | Silver                       |                                    | Mor                         | tgomer   | Y   |
| ang this bear | Funeral<br>Director   |                | 5. Social Security Number 080–38–689   | 90 1                    | x 7. Age   | e (In yrs. Ia<br>62          | st birthday)<br>Yrs.       | If Under 1 Year<br>Months Days                                  | If Under 24 Hrs<br>Hours Min | (Month, Da                         | h<br>ly, Year)<br>19/1945   | 9. Birthp<br>Coun<br><b>NY</b>                   | ace (State or Foreign<br>try)                           |
|               | land<br>ow  |                | Usual Residence of Dec<br>10a. State 10b   | cedent<br>c. County     |  | 10c. City,                   | Town or Lo                 | cation  |                              |                                    |                             | 11   | 0d. Inside City Limits                                  |
|               | a-f sh  | ctor           | MD   | Montgon                 | ery  | Sil                          | lver S                     | pring   |                              |                                    |                             |  | 1 ☐ Yes 2 💢 No  |
|               | or 28   | Director       | 10e. Street and Number   |                         |  |                              |                            | 10f. Zip Code   |                              | -                                  | 10g. Citizen                |  | •   |
|               | eath w  | Funeral        | 11419 Oak  | Leaf Di                 | 12. Was Decedent B   | Ever in U.S                  | . 13. \                    | 20901   |                              | Specify Yes or No                  |                             | ed Sta   |   |
| 136           | be filed within 72 hours after death with the Maryland that Hyglene.  dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by             | 1 ⊠Never Married 3 □ Widowed 4 □   |                         | Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:                  |                              |                            | Vas Decedent of H<br>f Yes, specify Cuba<br>I □ Yes 2⊠No        | an, Mexican, Pue<br>Specify: | rto Rican, etc.)                   | E                           | lack, White, o                                   | etc.  |
| 15-0036       | 72 ho   | eted           | 15.<br>(Specify o  | Decedent's Edu          | ucation<br>le completed)   | Ţ                            | 16a. Deced                 | lent's Usual Occup<br>kind of work done o<br>OO NOT use retired | ation<br>during most of we   | orking                             |                             | Business/Ind                                     | dustry<br>vernment                                      |
| 7             | within 72<br>ene.<br>than "na<br>he Medic   | Completed      | Elementary/Secondary   | y (0-12)                | College (1-4or 5   | +)                           |                            | 00 NOT use retired<br>ntist                                     | 1)                           | -                                  | reae                        | rai Go   | vernment  |
| מַק           | 12 should be filed w<br>h and Mental Hygie<br>I s marked other t<br>raumatic event, th  | Be Co          | 17. Father's Name (First   | t, Middle, Last)        |  | •                            |                            |   | 18. Mother's Na              | me (First, Middle                  | , Maiden Surr               | name)  |   |
| yiar          | Menta<br>arked<br>atlc ev   | To E           | Vincent  |                         |  |                              |                            |   |                              | Schlachte                          |                             |  |   |
|               |   |                | 19a. Informant's Name/   |                         |  |                              | 108                        | g Address (Street of D1 Lockwo                                  | od Dr.                       |                                    | -                           |  | *   |
| Baltimore,    | permit. Pages 1 an<br>Department of Heal<br>Important: If item 2<br>any Injury or other<br>once.  |                | 20a. Method of Dispositi<br>1 ☐ Burial 2 ☑ Cr<br>4 ☐ Donation 5 ☐  | remation 3 🔲            |  | -                            | esape                      | sition (Name of<br>natory or other place<br>ake Crema           | tory                         | Feb 13<br>2008                     | Belts                       | n - City or To                                   | wn, State  Maryland                                     |
| Rail          | permit<br>Depari<br>Impori<br>any In  |                | 21. Signature of Funera  | Service Licens          | un M   | 00382                        | 2 22                       | Name and Addre<br>Rapp Fune:<br>933 Gist                        |                              | emation Se<br>ver Spri             |                             | yland 2  | 0910-   |
|               |   |                | 23a. Part1. Enter the di<br>shock, or heart fai  |                         | lications that caused<br>one cause on each lin                           | the death.<br>ne.            | Do not ent                 | er the mode of dyin   | ig, such as cardi            | ac or respiratory a                | rrest,                      |  | Approximate<br>Interval Between<br>Onset and Death      |
|               | Physician /<br>/Medical   |                | Immediate Cause (Final disease or condition resulting in death)  |                         | a. Hewte   |                              |                            | heal in Fe  | erction                      |                                    |                             |  |   |
|               | Examiner  |                |  | - 1                     | Attend   | 1                            | 5 (S                       |   |                              |                                    |                             |  |   |
|               | D #   | iner           | Sequentially list condition any, leading to immediately cause. Enter Underlying Cause (Disease or injurthat initiated events | ons,<br>diate           | Due to (or ac  | The Management of            |                            |   |                              |                                    |                             |  |   |
|               | xecute<br>and<br>al-trans   | Examiner       | that initiated events resulting in death) Last   | y                       | c<br>Due to (or as   | a conseque                   | ence of):                  |   |                              |                                    |                             |  |   |
| 68/60,        | ificate be executed<br>g physician and<br>as the burial-transit   | edical E       |  | l                       | d  |                              |                            |   |                              |                                    |                             |  |   |
|               | ertifica<br>ding ph   |                | IF FEMALE:   |                         | 220 If you gutcome   | Df Drognan                   | 101                        |   |                              |                                    |                             |  |   |
| C. Box        | w requires that the death certific<br>been signed by the attending p<br>should be detached for use as   | Physician/M    | 23b. Was decedent pre<br>in the past 12 mon<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | nths?                   | 23c. If yes, outcome<br>1 ☐ Live birth<br>4 ☐ Pregnant at<br>9 ☐ Unknown | 2 Fetal                      | death 3                    | Ectopic pregnancy<br>Other (specify)                            | /                            |                                    | 23d.                        | Date of delive<br>Month                          | Day Year  |
| رپ<br>ح       | requires that the<br>een signed by th<br>nould be detache   | by Ph          | Part II. Other significan  |                         | -  | ut not resul                 | ting in the u              | nderlying cause giv   | en in Part I.                | 23e. Did                           | tobacco use c               | ontribute to th                                  | ne cause of death?                                      |
| ecords,       | equire  | ted k          | Diabetes   | Me II.                  | tus  |                              |                            |   |                              | . 1 🗆                              | Yes 2□N                     | 3 ☐ Prob   | ably 4 Unknown  |
| r             | The la  | Completed      |  |                         |  |                              |                            |   |                              | 24a. Was<br>auto<br>perf<br>1∐ Yes |                             | b. Were auto<br>prior to co<br>death?<br>1 ☐ Yes | psy findings available<br>mpletion of cause of<br>2□ No |
| VII           | Physician: Th<br>r this certificate<br>ral director, pag  | Be             | 25. Was case referred texaminer?   | 1                       | Hospital:  |                              |                            | oth   | or.                          | eath (Check only                   |                             |  |   |
| ō             | ding Physician:  After this certific funeral director,  | 7: To          | 1 ☐ Yes 2 No<br>27. Manner of Death  |                         | 28a. Date of Inju  | ry                           | R/Outpatier<br>28b. Time o | IL SUIDON   | 4 🗀 Nursing                  | Home 5 Res<br>28d. Describe        |                             |  | y)  |
| io<br>N       | ending<br>ath.<br>or: Afte<br>he fun  | atio           | 2 ☐ Accident   | Pending investigation   | (Month, Day  |                              | Injury                     | M 1 🗆   | k?<br>Yes 2 □ No             |                                    |                             |  |   |
| UIVISION      | spital or Atten<br>ours after deatl<br>ieral Director:<br>filled in by the  | Certification: | 3 ☐ Suicide 6<br>4 ☐ Homicide  | Could not be determined | 28e. Place of injubulding, etc.  | ury - At hor<br>c. (Specify) | ne, farm, str<br>)         | eet, factory, office  |                              | 28f. Location (<br>City or To      | Street and Nu<br>wn, State) | mber or Rura                                     | I Route Number,   |
| 7             | 4 t j e   | edical Ce      |  |                         | /sician: To the best<br>liner: On the basis o<br>and manner sta          | f examinati                  |                            |   |                              |                                    |                             |  |   |
|               | To the Hos<br>within 24 ho<br>To the Fur<br>completely  | Mec            |  | of certifier            | Cand marrier ste   |                              |                            | 29c. Licens   | e number                     |                                    | 29d. Date sig               | gned (Month,                                     | Day, Year)  |
| )             | 4   |                | ) Ch   |                         | × an   | y                            |                            | Do  | 04107                        | 2                                  | - 0                         | 2-10   | -08   |
| 1             | 27  |                | 30. Name and address   | * ^ -                   | completed cause of d   | eath (Item                   | 23a) (Type,                |   | 1                            | , ,)                               |                             |  | 1 00  |
|               | Z<br>Sta  | te.            | 31. Date filed (Month, D   | Day, Year)              | Parky M<br>37 Registr  | ar's Signati                 | ure 🖋                      | O Conne   | exicutt                      | Ave Ke                             | nsing                       | ton M  | ND 2089   |
| ľ             | Registi   |                | FFB  | 1 3 20                  | 08 Jane  | 1                            | A STATE OF                 | ME)   |                              |                                    |                             |  |   |

FFB 1 3 2008

|                        |  |                        | 1 - State of Mary Registrar  |                                | artment of H<br>rtificate of L  |                                |                                     | ene<br>g. No. 20         | 08 04075   |
|------------------------|--|------------------------|--|--------------------------------|---|--------------------------------|-------------------------------------|--------------------------|--|
| r                      | Physici  | an                     | 1. Decedent's Name (First, Middle, Last)   |                                |   |                                | Date of Death     Month             | Day                      | 3. Time of Death   |
|                        | /Media   | al                     | 4a. Facility Name (If not institution, give street and number)   |                                | 4h City Town or   | Location of Death              | Februa                              | 4c. County of            | 2008 7:00 AM   |
| ı                      | Examir   | er                     | thern Maryland Hospital  |                                | 45. Oily, Town, or  | Clinton                        |                                     | 1                        | ce George's  |
|                        | Funeral<br>Director  |                        | 5. Social Security Number  578-46-4084  6. Sex 1 □ M 2 ☑ F   | yrs. last birthday)<br>70 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, 10/20 | Year)                    | Birthplace (State or Foreign Country)     MD                                       |
|                        | w  |                        | Usual Residence of Decedent           10a. State         10b. County         10  | c. City, Town or Lo            | cation  |                                |                                     |                          | 10d, Inside City Limits  |
|                        | Maryli<br>f sho<br>led at  | or                     | MD Charles   | Waldorf                        |   |                                |                                     |                          | 1 XYes 2 □ No  |
|                        | r 28a  | Director               | 10e. Street and Number   |                                | 10f. Zip Code   |                                | 10                                  | g. Citizen of W          | hat Country?   |
|                        | th with  |                        | 11080 Weymouth ct. #325  |                                | 20603   |                                |                                     | United                   | States   |
| 2-0036                 | be filed within 72 hours after death with the Maryland Hygiene.  ad other than "natural", or Items 23a or 28a-f show et other than "natural", or Items 23a or 28a-f show event, the Medk-al Examiner must be notified at | ed by Funeral          | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:   |                                | Was Decedent of Hi<br>If Yes, specify Cuba<br>1 ☐ Yes 2 ☑ No                | Specify:                       |                                     |                          | White  |
| 2                      | within 72<br>iene.<br>than "nal<br>he Medica   | Completed              | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  11  College (1-4or 5+)   | (Give<br>life. L               | dent's Usual Occupa<br>kind of work done of<br>DO NOT use retired<br>emaker | luring most of work            | ing                                 | Own Ho                   |  |
| land 2                 | be do de   | To Be Co               | 17. Father's Name (First, Middle, Last)  Joseph Aloysius Hands Sr.   |                                |   | 18. Mother's Name              | e (First, Middle, Mangeline         |                          | •  |
| Mary                   | es 1 and 2 should<br>of Health and Men<br>item 27 is marke<br>other traumatic  | -                      | 19a. Informant's Name/Relationship (Type. Print) Michele C Castor/Daughter   | 1                              | ng Address (Street &<br>29 Trinit   |                                |                                     | -                        |  |
| Baitimore, Maryland 21 | Pages 1 a<br>nent of Hea<br>int: If item<br>iny or othe  |                        | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  | -                              | sition (Name of<br>matory or other plac<br>ake Crema                        | e)                             | Feb 9 2008                          |                          | City or Town, State  |
| Balti                  | permit. Page<br>Department of<br>Important: If<br>any Injury or<br>once,   |                        | 21. Signature of Funeral Service Licensee)  Will Hold Holdman  | 0382 22                        | 2. Name and Address<br>Rapp Fune:<br>933 Gist A                             | ral & Crem                     |                                     |                          | and 20910-   |
| ,                      | Physician<br>/Medical<br>Examiner  | Examiner               | 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, hading to himsolate cause. Enter Underlying Cause (Disease or injury | Chroni                         | er the mode of dying  |                                |                                     |                          | Approximate Interval Between Onset and Death CIT Known                             |
| . Box 68760,           | death certificate be executed<br>attending physician and<br>I for use as the burial-transit  | Physician/Medical Exar | Life FEMALE:  23b. Was decedent pregnant in the past 12 months?  | regnancy                       | ]Ectopic pregnancy  |                                |                                     | 23d. Date<br>Mor         | e of delivery<br>hth Day Year  |
| <u>ч</u><br>О          | The law requires that the death cert<br>te has been signed by the attending<br>age 2 should be detached for use a  |                        | 1 ☐ Yes 2 1 € No 9 ☐ Unknown  Part II. Other significant conditions contributing to death but no   | ot resulting in the ur         | nderlying cause give  | en in Part I.                  | 23e. Did tob                        | acco use contri          | ibute to the cause of death?   |
| cords                  | v requires<br>been sign<br>should be   | eted by                |  |                                |   |                                | 1 ☐ Ye                              |                          | 3 ☐ Probably 4 X Unknown   |
| Vital Records,         |  | Completed              |  |                                |   |                                | autops<br>perform<br>1☐ Yes 2       | y p<br>ned? d<br>IX No 1 | Vere autopsy findings available rior to completion of cause of eath?  ☐ Yes 2 ☑ No |
| <b>=</b>               | siclar<br>certif   | o Be                   | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☑ Inpatient  | 2 ☐ ER/Outpatien               | othe Othe   | 26. Place of Deat              |                                     |                          | (0 / 1/2)  |
| Division or            | nding Phy<br>th.<br>: After this<br>e funeral d  | Ηď                     | 27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident investigation   | 28b. Time of                   | f 28c. Injury<br>Work   | 4 □ Nursing Ho                 | me 5 ☐ Reside<br>28d. Describe ho   |                          |  |
| DIVIS                  | To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director; p   | Certification:         | 3 Suicide 6 Could not be determined 28e. Place of injury building, etc. (S   |                                | eet, factory, office  |                                | 28f. Location (Str<br>City or Town  |                          | er or Rural Route Number,  |
|                        | the Hospi<br>in 24 hour<br>the Funerappletely fills  | Medical (              | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examiner and manner stated   | amination and/or in            | vestigation, in my o  | pinion, death occur            | red at the time, da                 | ate and place, a         | and due to the cause(s)  |
| )                      | To t<br>To t   |                        | 29b. Signature and title of certifier  Recofer For M   |                                |   | 43646                          |                                     | 2.8.                     |  |
| 11                     | )  |                        | 30. Name and address of person who completed cause of death ROINTAN FARAHIFAM M. 31. Date filed (Monthly Yar) 2008 32 bodistrar's  | (Item 23a) (Type,<br>0 9801    | Print)<br>Georgia   | Ave Suit                       | 3-41 5:                             | Iva sp                   | rig MD 20902   |
|                        | Sta<br>Registr   | te<br>ar               | 31. Date filed (Month P.B. Year) 2008 32 Registrar's   | Signature                      | 1845  |                                |                                     |                          |  |

2008 04076

| Emmanuel M.<br>08-01097<br>UNK UNK   | icho              | Please Type or Prin  | nt in Black Inde   | elible Ink. En                        | sure All Co   | <b>pies Are Leg</b><br>I Hygiene             | ible. 20   | 08 0407  |
|--|-------------------|--|--|---------------------------------------|---|--|--|--|
| ON ON  | Do                | or State   | Certifi  | icate of Death                        |   | Reg  | g. No.   | 3. Time of Death   |
| Physician  | 1.                | Decedent's Name (First, Middle,Last) Emmanuel Michael                              | Brvant.  | ĽV                                    |   | 2. Date of Death<br>Month<br>February 7      |  | 1305 hrs   |
| Merical Examine  |                   | . Facility Name (if not institution, give street a                                 |  |                                       | own, or Location of I   |  | 4c. County of Deat                                       | h  |
|  | -10               | University Hospital  | _  | Baltim                                |   |  | N/A  | irthplace (State or  |
| Funeral<br>Director  |                   | Social Security Number 6. Sex 1 2 - 1 1 - 2 6 5 6                                  | 7. Age (In yrs. fast   | birthday) If Unde<br>Months<br>Yrs.   |   | Min  | Fore   |  |
| d<br>how any<br>E.   | 1                 | ual Residence of Decedent a. State MD 10b. County Baltimore                        |  | wn or Location<br>Hale                | thorpe  |  |  | 10d. Inside City Limits 1 Yes 2XXNo                                    |
|  | Dire              | ne. Street and Number<br>2932 Lakebrooke C   |  | l l                                   | 21227   |  | Og. Citizen of What Co<br>USA                            | erican Indian, Black,  |
| or items 23  | nue               | X Never Married 2 Married 1  | as Decedent Ever in U.S. med Forces? Yes 2 X No  | If Yes, specif                        | ent of Hispanic Origin<br>by Cuban, Mexican, F<br>No specify: | n? (Specify Yes or No<br>Puerto Rican, etc.) | White, etc.  |  |
| rs after<br>ural",   |                   | Widowed 4 Divorced If Yes, Gor Date  15. Decedent's Education (Specify only higher | S'   | 6a Decedent's Usual                   | Occupation (Give ki   | nd of work done                              | 16b. Kind of Busines                                     |  |
| 72 hour  | ete               |  | llege (1-4 or 5+)  |                                       | rking life. DO NOT u<br>tudent                                | se retired)                                  | Tesst (  | College  |
| 21215-0036 and be filed within 7 Mental Hygiene. marked other than event, the Medica                                   | Completed by      | 7. Father's Name (First, Middle, Last) Emmanuel Michael                            | Pryant T   |                                       | 18.Mother's   | Name (First, Middle,                         | Maiden Surname) rrison                                   |  |
| 2121!<br>Mild be fil<br>Mental F<br>marked<br>c event,   | e<br>Be<br>L      | 9a. Informant's Name/Relationship (Type, Pr  | int )  | 10h Mailing Address                   | S (Street and Numb  | ner or Rural Route Nu                        | mber, City or Town, Sta                                  | ate, Zip Code) re, MD 21223  |
| MD and 2 sho salth and true 27 is raumati  | -                 | Rosalind Harrisor  Oa. Method of Disposition                                       | 20b. Pl  | ace of Disposition (Na                | me of cemetery,   | Date   | 20c. Location - City                                     | or Town, State   |
| Oreges 1 at of He  |                   | 1 X Burial 2 Cremation 3 Rer   |  | ematory or other place  g Memoria     |   | 2/16/08                                      | Woodlaw  | a, MD  |
| Baltimore,<br>permit. Pages I an<br>Department of Hee<br>Important: If ite   | - 1               | 1. Signature of Funeral Service Licensee   |  | E240 1                                | Poictors  | town Rd                                      | Balt   | uneral Home  |
| Physician<br>'Medical<br>aminer  |                   | or condition resulting in death)  Due to b.  Sequentially list conditions,         | is that caused the death.  DIE Gunshot Wound  (or as a consequence of)  (or as a consequence of) | ds<br>:                               | of dying, such as of  | ardiac or respiratory at                     | rest, shock, or neart                                    | Approximate Interval<br>Between Onset and<br>Death                     |
| ed   | Examiner          | cause. Enter Underlying Cause c.   | (or as a consequence of  |                                       |   |  |  |  |
| executed<br>ian and<br>ial - transi  | ical              |  | ENDED  |                                       |   |  | 5-81-33  |  |
| Box 68760, e death certificate be the attending physic ed for use as the bur   | Physician/Medical | 3b. Was decedent pregnant in the past 12 months?                                   | Live birth  Pregnant at time of deal   | 2 Fetal deat                          |   | c pregnancy                                  | 23d. Date of del<br>Month                                | ivery<br>Day Year  |
| P.O. Boss that the dea   | by Phys           |  | Unknown  | esulting in the underlyi              | ng cause given in Pa  |  |  | te to the cause of death?  Probably 4 Unknown                          |
| ords,<br>law require<br>has been si  | Completed t       |  |  |                                       |   |  | topsy prio<br>rformed? dea                               | re autopsy findings available r to completion of cause of th? Yes 2 No |
| Vital Rec<br>ysician: The I<br>his certificate   | Be Co             | 25. Was case referred to medical   |  |                                       | Other   | (Check only one)                             | Residence 6  | Other:   |
| 1 of Vitz<br>ling Physici<br>After this of<br>funeral direc  | ို                | examiner? 1 Yes 2 No  27. Manner of Death  | al: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year) Feb 7, 2008                             | ER/Outpatient 3 ✓ 28b. Time of Injury | 28c. Injury at Wor  | k? 28d. Descrit                              | oe how injury occurred                                   |  |
| Division or Spital or Attendin tours after death neral Director: A filled in by the fu                                 | Certification:    | 5 Pending  | Peb 7, 2008<br>28e. Place of Injury - At h   | 1246 hrs<br>ome, farm, street, fact   | 1 Yes 2 ♥ ory, office building, e                             | etc. 28f. Locatio                            | n (Street and Number<br>n, State)<br>of Loudon Avenue, I | or Rural Route Number, City  |
| Division To the Hospital or Attend within 24 bours after death. To the Funeral Director: completely filled in by the a |                   | 4 V Homicide determined  | (Specify) Alley To the best of my knowled  | ige, death occurred at                | the time, date and p  | lace, and due to the c                       | ause(s) and manner a                                     | s stated.  |
| To the Hos<br>within 24 h<br>completely  | Medical           | one) 2 Medical Examiner: On and  | the basis of examination a manner stated.  | and/or investigation, in              | my opinion, death c   | occurred at the time, di                     | ate and place, and are                                   | (Month, Day, Year)   |
| ESES   | Me                | 29b. Signature and title of certifier  | M  |                                       | O.C.M.E.  | as .   | February 8,  |  |
| by   |                   | 30. Name and address of person who comp  | pleted cause of death (Iter  | m 23a)                                | at Politimara   | MD 21201                                     |  |  |
| 3  | state             | 31. Date filed (Month, Day, Year)  | Medical Examiner 32. Faistrar's Signa  |                                       | eet, Baltimore, I   | 1410   |  |  |
| Regis  |                   | 600  | 8 Blown .  | 13 Paris                              |   |  |  |  |

24

ARTHU.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ORIGINAL

2401 West Belvedere Ave Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death \_Month Vear **Physician** BERTHA BREAdmon her 5:00 A M JANUAZ 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BAIt(morze Black FRIARS CIRCLE CATONEVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F 213 26 3860 Director SOUTH Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at moli 1 Yes 2 No BAHIMURE CAtonsvilla Director 10e. Street and Number 10g. Citizen of What Country? FRIARS CIRCLE USA Black 21228 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 BIACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOSPITA 1 Registaced NURSE Grile 3 481 RS 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Beardnor Annie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2122 GEORGE WILSON /minister 6005 Black FRIARS CIRCLE CATONSUILLY Ind 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 21616 1 Burial 2 □ Cremation 3 □ Removal from State Baltimoer, Maryland Woodlawn CEm. 4 Donation 5 Dother (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility
Chatano-HARRIS FUNER 1 16 una
5240-44 REISTRESTOWN Rd BAL 9 Harris BAHO md. 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 years /Medical Due to (or as a consequence) f) Examiner Sequentially list conditions, if any teating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Physician/Medical Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Cerebrovascular 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

10

Registrar

516 Ni Rolling Rd, Smite 107

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Tamil Kuppusamy

FEB 1 3 2008

31. Date filed (Month, Day, Year)

D63188

2/13/2008

Catonsville, MD

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Thomas Martin Boyd February 09, 2008 9:30 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Towson Gilchrist Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 11 M 2□ F Months 220-18-9926 82 Director October 28,1925 Baltimore,MD. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County t be notified at 1 ☐ Yes 2X No Timonium Director Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 ns 23a o must b 2300 Dulaney Valley Road M-204 United States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

↑ ↑ Yes 2 ↑ No
If Yes, Give
Year or Dates: ₩ • ₩ • II 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married ō, 21215-0036 1 ☐ Yes 2\times No Specify: White Specify. 3K Widowed 4 □ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Director of Sales Jenn-Air Company Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked of traumatic ever Henry Boyd Edith Buckman ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timonium, Maryland 21093 : If Item 27 i 2141 Pine Valley Drive Mrs. Catherine B. Howard (Dau.) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Evans Funeral Chapel Feb.12,2008 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> eaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or neat failure. List only one cause on each line. 23a. Part Enter the dis shock, or healt failu Immedite Cause (Final disease or condition resulting in death) **Physician** RECTAL CANCER, METASTATIC YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (ot as a consequence of): The law requires that the death certificate be executed Exami physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PROSTATE CANCER, METASTATIC 1 Yes 2 No 3 Probably 4 Unknown Completed STROKE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page performed? 1∐ Yes 2 No ATRIAL FIBRILLATION To the Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 No မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident 5 Pending investigation Injury To the Funeral Director: After dearn.

To the Funeral Director: After the Funeral Director of the funeral of the fun 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D64395 FEBRUARY 10, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

DANIEUE DOBERMAN, MO

31. Date filed (Month, Day, Year)

2008 32. Registrar's Signature

()+

6565 N. CHARLES ST. SUITE 209 BALTIMITE MO 21204

|  | 1                | For State Registrar  | ate of Maryland / I  | Departmer<br><i>Certificat</i>          |                      |  | -                               | giene 20 (                          | 08040 80   |
|--|------------------|--|--|---|----------------------|--|---------------------------------|-------------------------------------|--|
|  |                  | Decedent's Name (First, Middle, Last)  |  |   |                      |  | 2. Date of De<br>Month          | ath                                 | 3. Time of Death   |
| Physician<br>/Medica   | 1                | Dale A. Bower Sr   |  |   |                      |  | Feb.                            | 10 20                               | 08 8:10A M   |
| Examine  | r '              | la. Facility Name (If not institution, give street   |  |   |                      | ocation of Death                         |                                 | 4c. County of                       |  |
|  |                  | 905 Wampler Road  5. Social Security Number 6. Sex   | 7. Age (In yrs. last bi  | irthday) If Unde                        |                      | River  If Under 24 Hrs.                  | 9 Date of Birl                  | Balti                               | 9 Birtholago (Ctato or Foreign                                 |
| Funeral<br>Director  |                  | 220-66-1014 <sup>¹∑™</sup>   |  | Yrs. Months                             | Days                 | Hours Min.                               | Sept.                           | 17,1957                             | Maryland   |
| Pu ,   | -                | Usual Residence of Decedent  10a, State 10b, County  | 10c. City, Tow   | un or Location                          |                      |  |                                 |                                     | 10d. Inside City Limits  |
| I et, IVIAI ylatifu Z I Z I D-0000  8 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene.  Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | .                | MD Baltimor  |  | Middle                                  | e Riv                | ver                                      |                                 |                                     | 1 □Yes 2 XNo   |
| the N  |                  | 10e. Street and Number   |  | 10f. Zi                                 | o Code               |  |                                 | 10g. Citizen of Wh                  | nat Country?   |
| 23a o  | Funeral Director | 905 Wampler Roa  | .d   | 1                                       | 21220                | )  |                                 | USA                                 |  |
| r deat   | au l             | A  | /as Decedent Ever in U.S.<br>rmed Forces?  | 13. Was Dece<br>If Yes, spe             | dent of His          | spanic Origin? (Sp<br>n, Mexican, Puerto | ecify Yes or No<br>Rican, etc.) | - 14. Race<br>Black,                | - American Indian,<br>, White, etc.                            |
| s afte   | Dy F             | ^  | ☐ Yes 2 1 No<br>Yes, Give<br>ear or Dates:   | 1 □ Yes                                 | 2 <b>□x</b> o        | Specify:                                 |                                 | Specify:                            | White  |
| 2 hour   | De l             | 15. Decedent's Education   | 168  | a. Decedent's Usu                       | al Occupa            | tion                                     | 1                               | 16b. Kind of Bus                    | iness/Industry   |
| thin 7   | Completed        | (Specify only highest grade con Elementary/Secondary (0-12)  | College (1.4er 51)   |   |                      | uring most of work                       |                                 |                                     | e River  |
| led wi<br>lygien<br>her th   | 5 -              | 10th   | A  | ssemble                                 |                      |  |                                 | Alrcrai<br>Maiden Surname           | t systems  |
| d be fi  | מַ               | 17. Father's Name (First, Middle, Last)  Jackie E. Bower   |  |   |                      |  | Jo Ma                           |                                     | 7  |
| should mark mark mark  | 2                | 19a. Informant's Name/Relationship (Type. F  | Print) 19  | b. Mailing Addres                       | s (Street a          |  |                                 | er, City or Town, S                 | State, Zip Code)   |
| 2 4 4 5 F  |                  | Cindy Bower / wi   | fe   | 905 War                                 | nplei                | r Road                                   | Baltim                          | ore MD                              | 21220  |
| es 1 s<br>of He<br>r other   |                  | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remo   | 20b. Place of cemet  | of Disposition (Na<br>ery, crematory or | me of<br>other place |  | Date                            |                                     | City or Town, State  |
| Dartillion Dermit. Pages Department of mportant: If it any injury or once.   |                  | 4 ☐ Donation 5 ☐ Other (Specify)   | Bayv   | riew Cre                                |                      | 1  | 2/08                            |                                     | ore MD   |
| partillore, permit. Pages 1 and Department of Heali Important: If item 2 any injury or other   | J                | 21. Signature of Funeral Service Licensee  | Paras  | 22. Name a                              |                      |  |                                 |                                     | Balto. MD<br>ex 21221  |
|  | +                | 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care                   | ons that caused the death. Do  | not enter the mo                        | de of dying          | g, such as cardiac                       | or respiratory a                | rrest,                              | Approximate  |
| Physician  | 4                | Immediate Cause (Final   | use on each line.  | helio                                   |                      |  |                                 |                                     | Interval Between<br>Onset and Death                            |
| /Medical   |                  | disease or condition resulting in death)   | Due to (or as a consequence  | . 10                                    | 1=1                  |  |                                 |                                     | 15CW-JAMAS   |
| Examiner   | ١                | Sequentially list conditions, b. —   | Due to for se a consequence  | 2 050:                                  |                      |  |                                 |                                     |  |
| red red  | nine             | Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury | Due to (or as a consequence  | e or):                                  |                      |  |                                 |                                     |  |
| execunand nand ial-tra   | Examiner         | that initiated events c<br>resulting in death) Last  | Due to (or as a consequence  | e of):                                  |                      |  |                                 |                                     |  |
| icate be executed physician and sthe burial-transit  | edical           | d  |  |   |                      |  |                                 |                                     |  |
| certifica<br>certifica<br>ding ph  | Med              | IF FEMALE:   |  |   |                      |  |                                 | CHITT.                              |  |
| attendir<br>for use  | Physician/Me     | 23b. Was decedent pregnant in the past 12 months?  | f yes, outcome pf pregnancy<br>I □Live birth 2 □ Fetal dea:<br>I □ Pregnant at time of death | th 3□Ectopic  <br>5□Other (s            |                      |  |                                 | 23d. Date<br>Mon                    | e of delivery<br>oth Day Year                                  |
| the de ched  | Sic              |  | Unknown  | 3 double (s                             | pecity/              |  |                                 |                                     |  |
| - = e  | by Pr            | Part II. Other significant conditions contribu   | iting to death but not resulting   | in the underlying                       | cause give           | en in Part I.                            | 23e. Did                        |                                     | bute to the cause of death?                                    |
| w requires been sign should be   |                  |  |  |   |                      |  | 1 🗆                             | Yes 27 No                           | 3 ☐ Probably 4 ☐ Unknown                                       |
| law ra   | ompleted         |  |  |   |                      |  | 24a. Was                        | psy p                               | Vere autopsy findings available rior to completion of cause of |
|  | Con              |  |  |   |                      |  | perf<br>1□ Yes                  |                                     | eath?<br>□Yes 2□No   |
| 70 0 2   | Be               | 25. Was case referred to medical examiner?   | ital:  | Dutantina OF F                          | Othe                 | 26. Place of Dea                         | 1                               |                                     | 10 11 1  |
|  | <u>د</u>         | 27. Manner of Death  | 8a. Date of Injury 28b   | . Time of                               | 28c. Injury<br>Work  | 4 LI Nursing H                           |                                 | idence 6 Othe<br>how injury occurre |  |
| Attending or death.  | atio             | Dending 5 Pending 2 Accident investigation   | (Month, Day Year)  | Injury M                                |                      | Yes 2 □ No                               |                                 |                                     |  |
| or Atte  | ertification:    | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 2   | <ol> <li>Place of injury - At home,<br/>building, etc. (Specify)</li> </ol>                  | farm, street, facto                     | ry, office           |  |                                 | (Street and Numbe<br>wn, State)     | er or Rural Route Number,                                      |
| ita<br>Israel  | O                | 29a. Certifier Certifying Physicia   | n: To the best of my knowled   | lae, death occurre                      | d at the tim         | ne, date and place                       | e, and due to the               | cause(s) and ma                     | nner as stated.  |
| e Hos<br>124 hc<br>e Fun<br>letely   | Medical          |  | On the basis of examination a and manner stated.   |   |                      |  |                                 |                                     |  |
| To th withir To th comp  | Me               | 29b. Signature and title of certifier  | 200  | 2                                       | 9c. License          |  |                                 |                                     | (Month, Day, Year)   |
|  |                  | Tay Clean  | w III  |   | VS                   | 0929                                     |                                 | 2/11                                | 2008   |
| 10   |                  | Nam and address of person who compl  | eted cause of death (Item 23a  | a) (Type, Print)                        | 02 5                 | T#7K                                     | - RAI                           | TIME 1                              | 12008<br>1021204   |
| Stat   | e_               | 31. Date filed (Month, Day, Year)  | 32. Regrar's Signature   | CILLY C                                 | 0                    |  | DAG                             | 11100                               | -120/  |
| Dogistus   |                  | FFD 1 9 201  | nb No  | He Andre                                | K B                  |  |                                 |                                     |  |

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

|           |  |                | For State Registrar   | State of Mar   |                              | partment of H<br>e <i>rtificate of L</i>  |  |   | ene 008                                       | 04081                                |
|-----------|--|----------------|---|--|------------------------------|---|--|---|---|--------------------------------------|
|           | Physici  | an             | 1. Decedent's Name (First, Middle, Las<br>Margaret  |  | Buchana                      | n   |  | 2. Date of Death<br>Month<br>Februar        | ry Day 11, ŽÕO                                | 3. Time of Death  8 5:15pm M         |
|           | /Medio   | Aug .          | 4a. Facility Name (If not institution, give   |  | Duchane                      |   | Location of Death                                      | T CDT dd1                                   | 4c. County of Dear                            |                                      |
|           | LAdmin   | CI             | Carroll Lutheran  | Village  |                              | We  | stminster  |   | Car   | roll                                 |
| *         | Funeral<br>Director  |                |   | ex 7. Age (  | In yrs. last birthda<br>Yrs. | y) If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                         | 8. Date of Birth<br>(Month, Day,<br>Oct. 14 | , 1916 9. Bird                                | thplace (State or Foreign<br>ountry) |
|           | land<br>t  |                | Usual Residence of Decedent  10a. State 10b. County   | 1  | 0c. City, Town or            | Location  |  |   |   | 10d. Inside City Limits              |
|           | death with the Maryland<br>rms 23a or 28a-f show<br>r must be notified at  | tor            | MD Car  | roll   |                              | West  | tminster   |   |   | 1 ⊡Yes 2 🛣 No                        |
|           | th the or 28a e noti   | Director       | 10e. Street and Number  |  |                              | 10f. Zip Code   |  | 10  | g. Citizen of What Co                         | ountry?                              |
|           | 23a c<br>ust b   |                | 200 St. Luke Cir  | c1e  |                              |   | 158  |   |   | USA                                  |
| ٥         | be filed within 72 hours after death with the Marylan ital Hygiene. et other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at  | / Funeral      | 11. Marital Status  1 ☐ Never Married 2 ☐ Married   | 12. Was Decedent Even<br>Armed Forces?<br>1 ☐ Yes 2 ☐ No<br>If Yes, Give   | er in U.S.                   | <ol> <li>Was Decedent of Hi<br/>If Yes, specify Cuba</li> <li>1 ☐ Yes 2 X No</li> </ol> | spanic Origin? (Spe<br>in, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)            | 14. Race - Ame<br>Black, Whit<br>Specify: Wh  | e, etc.                              |
| 2-0030    | hours<br>tural"<br>al Exa  | ed by          | 3 X Widowed 4 ☐ Divorced  15. Decedent's Ed   | Year or Dates:   |                              | cedent's Usual Occup  | ation  | 1.  | 16b. Kind of Business                         |                                      |
| ÿ         | in 72<br>n "na<br>Medic  | plet           | (Specify only highest gra   | de completed)  | (Gir                         | ve kind of work done of DO NOT use retired  | during most of worki<br>)                              | ng '  | TOD. TURG OF DUSINESS/                        | midustry                             |
| 7         | d with<br>giene<br>er tha<br>, the   | Completed      | Elementary/Secondary (0-12)   | College (1-4or 5+)   | LPN                          | V/ Libraria   | an   |   | Medical                                       | <u> </u>                             |
| yland     | 12 should be filed within hand Mental Hygiene.<br>h and Mental Hygiene.<br>7 is marked other than "fraumatic event, the Mec  | Be (           | 17. Father's Name (First, Middle, Last)   |  |                              | Ì   | 18. Mother's Name                                      | , ,   | faiden Surname)                               |                                      |
| <u>ya</u> | Men Men Marker   | ို             | Carroll Leslie  |  |                              |   |  | Hoover                                      |   |                                      |
| Mar       | s 1 and 2 should<br>f Health and Mer<br>item 27 is marke<br>other traumatic  |                | 19a. Informant's Name/Relationship (7   |  |                              |   |  |   | City or Town, State, 2                        |                                      |
| ā,        | tem 2  |                | Mrs. Ruth Myers ( 20a. Method of Disposition  |  |                              | ) Weller C:<br>position (Name of<br>rematory or other place                             |  |   | POC. Location - City or                       | r, MD 21158 Town, State              |
| Ē         | Pages<br>lent of<br>nt: If i   |                | 1 █ Burial 2 □ Cremation 3 □<br>4 □ Donation 5 □ Other (Specific  | Hemovai from State   |                              | e-Winters (   |  | /2008                                       | New Windso                                    | or, MD                               |
| Бантто    | permit. Pages 1 and 2<br>Department of Health a<br>Important: If item 27 is<br>any Injury or other tra   |                | 21. Signature of Fluneral Service Licen   | see 2  | 764                          | 22. Name and Addres   | ss of Facility NERAL HOM                               | E & CHAP                                    | EL, PA (Bo                                    | ox 195)                              |
| ı,        |  |                | 23a. Part1. Enter the disease, or companions shock, or heart failure. List only   | A  | e death. Do not e            | enter the mode of dyin  | g, such as cardiac                                     | or respiratory arre                         | est,  | Approximate<br>Interval Between      |
|           | Physician  |                | Immediate Cause (Final disease or condition   | on cause on caon line.   |                              | Demer   | 4.1  |   |   | Onset and Death                      |
|           | /Medical<br>Examiner   |                | resulting in death)   | Due to (or as a c  | consequence of):             | -   | 1110   |   |   | 1                                    |
|           | LAdiiiiiei   | _              | Sequentially list conditions  | b. Due to (or as a c   | consequence of):             |   |  |   |   |                                      |
|           | nsit   | mine           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a c  | orisequence orj.             |   |  |   | 53  |                                      |
| 5         | execunal and ial-tra   | Examiner       | resulting in death) Last  | Due to (or as a c  | consequence of):             |   |  | -   |   |                                      |
| 00/00     | ifficate be executed<br>g physician and<br>as the burial-transit   | edical         |   | .d   |                              |   |  |   |   |                                      |
| _         | ertifice<br>ing ph   |                | IF FEMALE:  |  |                              |   |  |   |   |                                      |
| J. BOX    | e death ce<br>ne attendi<br>ed for use   | hysician/M     | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 ☐ Yes 2 ☑ No  | 23c. If yes, outcome pf 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown   | Fetal death                  | B⊟Ectopic pregnancy Diagram Other (specify)   |  |   | 23d. Date of de<br>Month                      | livery<br>Day Year                   |
| ۲.        | hat the<br>d by t<br>letach  | Phy            | 9 ☐ Unknown  Part II. Other significant conditions c  |  | not reculting in the         | underlying cause give   | on in Part I   | 23e Did toh                                 | acco use contribute to                        | the cause of death?                  |
| S,        | signe<br>d be c  | þ              | Tarrii. Other significant conditions o  | onabuting to death but i   | not resulting in the         | underlying cause give   | on mer are i.  | 1 ☐ Ye                                      |   | robably 4 □Unknown                   |
| ecords    | w requ   | Completed      |   | ·  |                              |   |  | 24a. Was an                                 | 24h Ware a                                    | utopsy findings available            |
| Ď<br>L    | The lar<br>e has<br>age 2  | ошо            |   |  |                              |   |  | autops)<br>perform                          | prior to death?                               | completion of cause of               |
| <u>o</u>  | lan; T   | മ              | 25. Was case referred to medical  |  |                              |   | 26. Place of Death                                     | 1 Yes 2<br>1 (Check only one                |   | s 2□No                               |
| >         | hysicl<br>his ce<br>I direc  | To B           | examiner?<br>1 ☐ Yes 2 ☐ No   | Hospital: 1 ☐ Inpatient  | 2 ER/Outpat                  | ient 3 DOA Othe   | er: 4 Nursing Ho                                       | me 5 Reside                                 | nce 6 □Other (Spe                             | ecify)                               |
| 0 10      | ing Pl   |                | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Y                                       | (ear) 28b. Time              | / Worl  |  | 28d. Describe ho                            | w injury occurred                             |                                      |
| NISIO     | ttendi<br>death.<br>stor: /<br>the fi  | cati           | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be   |  | At home farm                 | M 1 ☐' street, factory, office  | Yes 2 □ No   | 20f Location (Ctr                           | mot and Number or D                           | ural Pauta Alumbau                   |
| <u> </u>  | lor A  | Certification: | 4 ☐ Homicide determined   | building, etc.   | (Specify)                    | street, factory, office   | .  | City or Town                                | reet and Number or R<br>, State)              | urai Houte Number,                   |
|           | To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as | edical C       | 29a. Certifier 1 Certifying Ph<br>(Check only one) 2 Medical Exam   | ysician: To the best of a<br>niner: On the basis of ea<br>and manner state | xamination and/or            | ath occurred at the tin<br>investigation, in my o                                       | ne, date and place,<br>pinion, death occurr            | and due to the ca<br>red at the time, da    | ause(s) and manner a<br>ate and place, and du | s stated.<br>e to the cause(s)       |
|           | To th<br>Within<br>To th<br>comp   | Me             | 29b. Signature and title of certifier   | 1 30 1   | ′                            | 29c. License  |  | 29  | d. Date signed (Moni                          | -                                    |
|           |  |                | 100   | Mell   |                              | 100   | 059943   | F   | EBNWY 1                                       | 2,2008                               |
|           | 10   |                | 30. Name and address of person who  | completed cause of dear  | YAR. SU                      | e, Print)   | ne stminst   | Y MO  | 2115)   |                                      |
|           | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)   | 32. Registrar's  | s Signature                  | Coalles   |  |   |   |                                      |
|           | Registr  | aı             | FER 1 3 21  | 008  | 41) A                        | 1999-19   |  |   |   |                                      |

|             |  | 1              | For State   | State of Maryland  | -                     | rtment of H  |   |   |                          | 2008  | 04082  |
|-------------|--|----------------|---|--|-----------------------|--|---|---|--------------------------|---|--|
|             |  |                | Registrar  1. Decedent's Name (First, Middle, Last)                           |  |                       | inouto or E  |   | 2. Date of Dea                          |                          |   | 3. Time of Death                                   |
|             | Physicia   | an             | ROUNID B  | DINI DINI  |                       |  |   | Month                                   | Day                      | 2008  | 5:00 p. M  |
| 3           | /Medic<br>Examin   |                | a. Facility Name (If not institution, give s                                  | treet and number)  | I                     | 4b. City, Town, or   | Location of Death                                     |   | 4c. Cc                   | ounty of Death                                |  |
|             | LAGIIIII   |                | BALTIMONE REHABILITI  | ATION EXTENDED   | CARE                  | BALT   | MORE  |   |                          | •   |  |
|             | Funeral<br>Director  | 1              | 5. Social Security Number 6. Sex 1244-94-1349                                 | 7. Age (In yrs. la   |                       | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs.<br>Hours Min.                        | 8. Date of Bird<br>(Month, Da<br>1-24-1 | h<br>9 54                | 9. Birthp<br>Coun<br>MARY                     | lace (State or Foreign<br>to)<br>LAND              |
|             | pg 🏖   | -              | Usual Residence of Decedent  10a, Slate 10b, County                           | 10c City   | Town or Lo            | cation   |   |   |                          | 1   | 0d, Inside City Limits                             |
|             | sho  |                |   |  | BALTIM                |  |   |   |                          |   | 1√2 Yes 2 No                                       |
|             | 280-1  | Director       | MD . N/A  |  | MLILI                 | 10f. Zip Code  |   | 1                                       | 10g. Citize              | n of What Cour                                | itry?  |
|             | 3a or  |                | 2411 W. COLDSPRIN   | G LANE   |                       | 2121   | 1.5   |   |                          | USA   |  |
| 9           | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hyglene. Depertment of Health and Mental Hyglene important: if Item 27 is marked other then "neturel", or Iteme 23e or 28e-f show sayl hjury or other traumatic event, the Mydral Examiner must be notified at ance. | Fur            | 11. Marital Status 1 ☐ Never Married 2 ☑ Marned                               | 12. Was Decedent Ever in U.S<br>Armed Forces?<br>1 X Yes 2 ∏ No                |                       | Vas Decedent of Hi<br>Yes, specify Cuba                          | ispanic Origin? (Si<br>n, Mexican, Puerto<br>Specify: | pecify Yes or No<br>Rican, etc.)        |                          | Race - Americ<br>Black, White,<br>Decify: BLA | etc.   |
| 5-0036      | urel',   | d by           | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates:   | 10- D                 |  |   |   |                          |   |  |
| 2           | "neti  | Completed      | 15. Decedent's Edu<br>(Specify only highest grade                             | completed)   | (Give                 | lent's Usual Occupa<br>kind of work done o<br>DO NOT use retired | during most of wor                                    | king                                    | 16b. Kind                | of Business/Inc                               | bustry   |
| 2121        | withir<br>ene.<br>then   | dmo            | Elementary/Secondary (0-12)<br>-12-   | College (1-4or 5+)<br>-0-  |                       | ABORER   | /   |   | CON                      | STRUCTI                                       | ON   |
| ם<br>מ      | filed<br>Hygid<br>other  | Be Co          | 17. Father's Name (First, Middle, Last)                                       |  |                       |  | 18. Mother's Nan                                      | ne (First, Middle,                      | Maiden S                 | ımame)  | -  |
| Maryland    | should be and Mental s marked o  | To B           | JOSEPH BOULDIN  |  |                       |  | ANNII   | McCLAI                                  | N                        |   |  |
| ary         | should be  |                | 19a. Informant's Name/Relationship (Type                                      | pe, Print)   | 19b. Mailin           | g Address (Street a  | and Number or Ru                                      | ral Route Numb                          | er, City or T            | own, State, Zip                               | Code)  |
|             | and 2<br>saith<br>n 27 i   | 1              | SARAH ANN BOULDIN   |  |                       |  | SPRING LA   |   |                          |   | AND 21215  |
| ore         | of He  |                | 20a. Method of Disposition 1 ☑Burial 2 ☑Cremation 3 ☐R                        |  | metery, cren          | sition (Name of<br>natory or other plac                          | (9)   | Date                                    |                          | tion - City or To                             |  |
| Ĕ           | Pages<br>Iment of I<br>tant: If It<br>jury or o  |                | 4 □ Donation  Other (Specify)   | GARR.  |                       | OREST VET  |   |   |                          |   | S, MARYLAND  |
| Baltimore,  | permit<br>Deper<br>Impor<br>eny In   |                | 21. Signature of Fineral Service Literature                                   | U. HuBi  | 1 لــــ               | 721-27 N.  | . MONROE  | ST. BAL                                 | TIMOR                    | E, MARY                                       | LAND 21217   |
|             |  |                | 23a. Part1. Fn er the disease, or complishock, or heart failure. List only or | cations that caused the death<br>ne cause on each line.                        | . Do not ent          | er the mode of dyin  | g, such as cardiac                                    | or respiratory a                        | rrest,                   |   | Approximate<br>Interval Between<br>Onset and Death |
| 1           | Pnysician  | 1              | Immediate Luse (Final disease or Undition                                     | CANCER   | . PROS                | STATE U  | 11TH ME   | TASTA                                   | 515                      |   |  |
|             | /Medical<br>Examiner   |                | resulting in death)   | Due to (or as a consequ  |                       |  |   |   |                          |   |  |
|             | 2  | -              | Sequentially list conditions, if any, leading to immediate                    | Due to (or as a consequ  | ence of):             |  |   |   |                          |   |  |
|             | nsit   | Examiner       | Cause (Disease or injury  |  |                       |  |   |   |                          |   |  |
| Ć,          | execu<br>n and<br>ial-tra  | Exal           | that initiated events<br>resulting in death) Last                             | Due to (or as a consequ  | ence of):             |  |   |   |                          |   |  |
| 8760,       | sate be executed obysicien and the burial-transit  | cal            |   | d  |                       |  |   |   |                          |   |  |
| 9           | ifficat<br>og phy<br>as th   |                |   |  |                       |  |   |   |                          |   |  |
| Вох         | th cer<br>tendir<br>rr use   | an/N           | 230. Was decedent pregnant  | 3c. If yes, outcome of pregnar<br>1 Live birth 2 ☐ Fetal                       |                       | Ectopic pregnancy  | ,   |   | 23                       | d. Date of delive<br>Month                    | ery<br>Day Year                                    |
| 0           | law requires thet the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit   | Physician/Med  | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                             | 4□Pregnant at time of de<br>9□ Unknown   | eath 5                | Other (specify)  |   |   |                          |   | ,  |
| <u>a.</u>   | het th<br>id by<br>Jetacl  | F.             | Part II. Other significant conditions cor                                     | ntributing to death but not resu   | ilting in the u       | nderlying cause gry  | en in Part I.   | 23e. Did                                | obacco use               | contribute to t                               | he cause of death?                                 |
| Records,    | signed to det  | d b            | DIFFUSE BO  |  | TAS                   | 15   |   | 10                                      | Yes 2                    | No 3 ☐ Prol                                   | pably 4 Munknown                                   |
| Ö           | w requir<br>been si<br>should  | Completed      |   |  |                       |  |   | 24a. Was                                | an                       | 24b. Were auto                                | ppsy findings available                            |
| Rec         | The lay  | E D            |   |  |                       | 7.   |   | auto                                    | psy<br>ormed?            | prior to co<br>death?                         | impletion of cause of                              |
| ā           | icien: Th<br>certificete<br>rector, pag  | ပိ             | 25. Was case referred to medical  |  |                       |  | 26 Place of Dec                                       | 1 ☐ Yes                                 | 2 No                     | 1 🗆 Yes                                       | 2LI NO   |
| Vital       | ysicien: The<br>is certificete ha<br>director, page  | To B           | evaminer?   | Hospital: 1 ☐ Inpatient 2 ☐ 1  | ER/Outpatier          | nt 3 DOA Oth   | 00  | lome 5□Res                              |                          | Other (Speci                                  | fy)  |
| 10          | ਦੂ ÷ ਫ਼  |                | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year)                                       | 28b. Time o<br>Injury |  |   | 28d. Describe                           |                          |   |  |
| ion         | ath.<br>rr: After  | atlo           | 1 Matural 5 ☐ Pending<br>2 ☐ Accident investigation                           | (World, Day You)   | inquiy                |  | Yes 2 □No   |   |                          |   |  |
| Division of | or Attendethefter death  | Certification: | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined                       | 28e. Place of Injury - At ho building, etc. (Specify                           |                       | eet, factory, office   |   |   | Street and<br>wn, State) | Number or Run                                 | al Route Number,                                   |
|             | Hospital of the hours of Funeral Distribution tely filled in   |                | 20a Cartifier W Cartifica St.   | pician: To the best of and   | ulades dest           | h occurred at the fi   | no date and sice                                      | and due to the                          | cauco/o) -               | nd manner as                                  | hetet  |
|             | To the Hospital or Attending within 24 hours efter death.  To the Funeral Director: After completely filled in by the funer  | Medical        |   | sician: To the best of my knowner: On the basis of examinat and manner stated. |                       |  |   |   |                          |   |  |
|             | To the Ho<br>within 24 I<br>To the Fu<br>completely  | Me             | 29b. Signature and title of certifier   | 1.   | h                     | 29c. Licens  | e number  |   | 29d. Date                | signed (Month,                                | Day, Year)   |
|             | - 10   |                | AMMANA C  | an. Mr   | 0,                    | 101  | 4958  |   | 021                      | 06/3  | 2008   |
| ١,          | 110  |                | 30. Name and address of person who co   | ompleted cause of death (Item  | 23a) (Type,           | Print) AU  | ROPA (  | N. IA                                   | N. I                     |   |  |
| 1           | [+]  |                | 3900 LOCH RAV   | EN BULLEV  | ARD,                  | RALTIN   | MILE,   | MY                                      | 212                      | 18  |  |
|             | Sta<br>Regist  | ate<br>rar     | 31. Date filed (Month, Day, Year)   | 32. Registrar's Signa  | ture                  | July   |   |   |                          |   |  |

|                     |  |                | 1 - State amend #5 Per  | State of Maryla<br>FH G876 2/I   | 3968 <del>Ce</del>                     | artment o<br>Î<br><i>rtificate d</i>                   | f Health<br>Of Deat           | n and Me<br><i>h</i>          | ental Hy                       | giene<br>Reg. No. 2               | 00                              | 04083   |
|---------------------|--|----------------|---|--|--|--|-------------------------------|-------------------------------|--------------------------------|-----------------------------------|---------------------------------|---|
| 5                   | Physici  | an             | 1. Decedent's Name (First, Middle, Last)  | ch   |  |  |                               |                               | 2. Date of De                  | ath Day                           | Year                            | 3. Time of Death                              |
|                     | /Medic<br>Examin   |                | 4a. Facility Name (If not institution, give str   | reet and number)   |  | 4b. City, Tow  | n, or Locatio                 | n of Death                    | 165                            | 4c. Coun                          | ZCC<br>ity of Death             |   |
|                     | Funeval  | ,              | Mercy Medical  5. Social Security Number 6. Sex   | (enter   | s. last birthday)                      | Bal<br>If Under 1 Ye                                   | HIMO                          |                               | 8. Date of Bir                 |                                   | /A                              | place (State or Foreign                       |
| В                   | Funeral<br>Director  |                | 140-20-07.75<br><del>40-20-07.75</del> 1東   | M 2□F 80   | Yrs                                    | Months Da  |                               |                               | (Month, Da                     | y, Year)<br>-1927                 | Cou                             | w JERSEY                                      |
|                     | yland<br>low<br>at   |                | Usual Residence of Decedent  10a. State 10b. County   | 10c. C   | City, Town or Lo                       | ocation  |                               |                               |                                |                                   |                                 | 10d. Inside City Limits                       |
|                     | he Mar<br>8a-f sh<br>ptiffied  | Director       | MD, N/A   |  | BALTIMO                                |  |                               |                               |                                |                                   |                                 | 1∏Yes 2□No                                    |
|                     | a with t   |                | 10e. Street and Number 301 McMECHEN ST.   | APT 1209   |  | 10f. Zip Coo   | 1e<br>21217                   |                               |                                | 10g. Citizen o                    | f What Cou                      | intry?  |
|                     | r deat   | Funeral        | 11. Marital Status  | 2. Was Decedent Ever in<br>Armed Forces?                               | U.S. 13.                               | Was Decedent<br>If Yes, specify (                      |                               | Origin? (Spec                 | cify Yes or No<br>Rican, etc.) | - 14. R                           | ace - Ameri<br>lack, White,     |   |
| 036                 | be filed within 72 hours after death with the Maryland that Hygiene.  did other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at | þ              | 1 ☐ Never Married 2 Ă Married<br>3 ☐ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 ☐ No<br>If Yes, Give X<br>Year or Dates:                     |  | 1 ☐ Yes 2 🔀  | No Speci                      | fy:                           |                                | Spec                              | ify: B                          | LACK  |
| 15-0                | n 72 hc<br>"natur<br>edical  | Completed      | 15. Decedent's Educa<br>(Specify only highest grade of  | completed)   | 16a. Dece                              | edent's Usual Oc<br>e kind of work do<br>DO NOT use re | ccupation<br>one during m     | ost of workin                 | ıg                             | 16b. Kind of                      | Business/Ir                     | ndustry                                       |
| 212                 | filed withi<br>Hygiene.<br>ther than<br>int, the M   | Somp           | Elementary/Secondary (0-12)   | College (1-4or 5+)   |  | CHANIC   |                               |                               |                                | AU                                |                                 |   |
| and                 | should be filed<br>and Mental Hygin<br>marked other<br>matic event, til  | Be             | 17. Father's Name (First, Middle, Last) UN  | NKNOWN   |  |  | 18. Mot                       | ther's Name                   | (First, Middle                 | , Maiden Surna                    | ame) UN.                        | KNOWN   |
| Maryland 21215-0036 | d 2 should<br>th and Men<br>7 Is marke<br>traumatic  | 욘              | 19a. Informant's Name/Relationship (Type  | . Print)   | 19b. Maili                             | ng Address (Str  | reet and Nun                  | nber or Rural                 | l Route Numb                   | er, City or Tow                   | n, State, Zi                    | p Code)                                       |
|                     | 1 an<br>Healt  |                | MARGARET BUSH (WII  |  | Place of Dispo                         | osition (Name o  | f :                           |                               | 1209 BA                        | LTIMOR<br>20c. Location           |                                 | RYLAND 2121                                   |
| Baltimore,          | 0 - F  |                | 1 ☐ Burial 2 🗖 Cremation 3 ☐ Rer<br>4 ☐ Donation 5 ☐ Other ( <i>Specify</i> )                               | moval from State   | cemetery, cre                          | matory or other<br>EMATORY                             | place)                        | 2-11-                         | -2008                          |                                   | -                               | MARYLAND                                      |
| Balt                | permit. Pag<br>Department<br>Important; I<br>any Injury c  |                | 21. Signature of Funeral Service Licensee   | O KAHTAMO.   | HIBNER                                 | 2. Name and A  |                               | cility PHII                   | LLIPS I                        | UNERAL                            | HOME                            | , P.A.  |
| F                   |  |                | 23a. Part1 Enter the disease, or complica shock or heart failure. List only one                             |  |  |  |                               |                               |                                |                                   | _MARY                           | LAND 21217  Approximate Interval Between      |
|                     | Physician /  |                | Immediate Cause (Final disease or condition resulting in death) a.  | Probable   | MYYO                                   | cardie   |                               |                               |                                |                                   |                                 | Onset and Death MINUTCS                       |
|                     | Examiner   |                |   | Due to (or as a conse  | equence of:                            |  |                               |                               |                                |                                   |                                 |   |
|                     | ted<br>iii   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conse  | equence of):                           |  |                               |                               |                                |                                   |                                 |   |
| Ď,                  | icate be executed physician and sthe burial-transit  | Exar           | that initiated events c. resulting in death) Last   | Due to (or as a conse  | quence of):                            |  |                               |                               |                                |                                   |                                 |   |
| 98/89               |  | edical         | d   | <u> </u>   |  |  |                               |                               |                                |                                   |                                 |   |
| ROX                 | w requires that the death certil<br>been signed by the attending<br>should be detached for use a   | an/Me          | 230. Was decedent pregnant  | c. If yes, outcome pf preg<br>1 □ Live birth 2 □ Fe                    | nancy<br>tal death 3                   | ⊒Ectopic pregn   | ancv                          |                               |                                |                                   | Date of deliv                   | •   |
| j.                  | the dea<br>/ the at<br>ched fo   | Physician/M    | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 4□Pregnant at time of 9□Unknown  |  | Other (specify   |                               |                               |                                | , n                               | Month                           | Day Year                                      |
| S,                  | es that<br>gned by   | by Ph          | Part II. Other significant conditions contri  |  | =                                      |  | _                             | rt I.                         | 23e. Did t                     | obacco use co                     | ntribute to                     | the cause of death?                           |
| Sord                | v requir<br>been si<br>should  | eted           | bluveter, Hype  | rtension,  | Rena                                   | Hall   | UQ                            |                               |                                | Yes 2 No                          |                                 |   |
|                     |  | Completed      |   |  |  |  |                               |                               | 24a. Was<br>auto<br>perfo      | an 245<br>psy<br>prmed?<br>2 □ No | prior to co<br>death?<br>1 \Box | opsy findings available ompletion of cause of |
| VII                 | slcian;<br>certific<br>rector,   | Be             | 25. Was case referred to medical examiner?  | spital:  |  |  | Other:                        |                               | (Check only o                  | one)                              |                                 |   |
| יס ר                | rg Physter this neral di   | n: To          | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year)                               | ER/Outpatier<br>28b. Time of<br>Injury | III DOM  | njury at<br>Work?             |                               |                                | dence 6 🗆 O                       |                                 | ify)  |
| DIVISION            | ttendir<br>death.<br>ctor: Af<br>/ the fu  | icatio         | 2 Accident investigation 3 Suicide 6 Could not be   | 28e. Place of injury - At  |  | М  | 1 ☐ Yes 2                     |                               | Of Landing (                   | Ct                                |                                 | -/  |
| 2                   | tal or A s after al Direct ed in b)  | Certification: | 4 Homicide determined   | building, etc. (Spec   |  | reet, ractory, on                                      | 108                           | 20                            | City or To                     | vn, State)                        | iber or Hur                     | ral Route Number,                             |
|                     | To the Hospital or Attending Physician: white 24 hours after deals.  To the Funeral Director; After this certifica completely filled in by the funeral director;           | edical         | 29a. Certifier (Check only one)  Certifying Physic 2 Medical Examine  | r: To the best of my kr<br>r: On the basis of examinand manner stated. | nowledge, deat<br>nation and/or ir     | th occurred at th                                      | e time, date<br>ny opinion, d | and place, a<br>leath occurre | and due to the ed at the time, | cause(s) and i<br>date and place  | manner as :<br>e, and due       | stated.<br>to the cause(s)                    |
|                     | To the comply  | Me             | 29b. Signature and title of certifier   | and marrier stated.  |  | 1 ~ .  | ense numbe                    | r                             |                                | 29d. Date sigr                    |                                 |   |
|                     |  |                | 30 Name and address of paramy who   | NIL  | ) , am 220) (T:                        |  | 046                           | 46                            | Įł                             | ebnuo                             | my -                            | 1,2008  |
|                     | 7  |                | 30. Name and address of person who com HNITO TSEN, 30   | 187, Paul  | Place                                  | , Bai  | hmon                          | re                            | MD                             | 2120                              | )2                              |   |
|                     | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)   | 32. Registrar's Sign   | nature                                 | Sounds   | 0                             |                               |                                |                                   |                                 |   |

DHMH 17 Rev 1/2001

08-00970 Phillip Earl Cla

Mé

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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|   |   |   |   |   |   |   |   |   |

| ıp E       | arı C   | laik,  |              | - Fo           | r State                             | State                                | Of Maryland /  | Certific         | ate of                  | Death                    |               |                    |            | R                    | eg. No.             |                  |                       |   |
|------------|---|--|--------------|----------------|-------------------------------------|--------------------------------------|--|------------------|-------------------------|--------------------------|---------------|--------------------|------------|----------------------|---------------------|------------------|-----------------------|---|
| _          | Disco   |  | F            |                | +                                   | e (First, Middle,Las                 | t)   |                  |                         |                          |               |                    |            | Date of Dea<br>Month | Day                 | Year             |                       | Time of Death<br>1349 hrs                 |
| ÷.         | Phys  | sıcıa<br>amin  |              |                | hilip                               |                                      | Earl   |                  | Cla                     |                          | Jı            |                    | F          | ebruary              | 3, 200              | 8                |                       | 1345 1115                                 |
|            | 7   |  |              | 4a. F          | acility Name (ii                    | f not institution, giv               | re street and number)  |                  | 41                      | . City, Tow              |               |                    | Death      |                      |                     | County of        | Death<br>County       | ,   |
|            |   |  |              |                |                                     | crest Avenue                         |  |                  |                         | Sparrov                  |               |                    |            |                      |                     |                  |                       |   |
|            | F   |  | -            | 5. S           | ocial Security N                    | lumber 6. S                          | ex 7. Age  | (In yrs. last bi | rthday)                 | If Under                 |               | If Under           |            |                      |                     |                  | roreidii              | ace (State or                             |
|            | Fune<br>Direc   |  |              |                | 6-72-                               |                                      | X <sub>M</sub> 2 F   | Δ                | 8 Yrs.                  | Months                   | Days          | Hours              | Min.       | May 1                | 3,19                | 59               | Countr                | y)Maryland                                |
|            |   |  |              | _              |                                     |                                      | 2 t  |                  |                         | L                        |               |                    | L          |                      |                     |                  |                       | Ob. Limite                                |
|            |   | »  | ŀ            | _              | al Residence of<br>. State          | 10b, County                          |  | 0c. City, Tow    | n or Location           | on                       |               |                    |            |                      |                     |                  |                       | d. Inside City Limits                     |
|            |   | æ<br>≱   |              |                | · otato                             | · ·                                  |  |                  | Fda                     | emere                    |               |                    |            |                      |                     |                  | ] 1                   | Yes 2 XNo                                 |
|            | land  | f sho  | 힏            | Ма             | ryland                              | Baltimo                              | ore  |                  | Bag                     | 10f. Zip C               |               |                    |            |                      | 10g. Citi           | zen of Wh        | at Country            | ?   |
| -          | Mary  | 28a  | Director     |                | . Street and Nu                     |                                      |  |                  |                         |                          | 2121          | 19                 |            | 1                    |                     | USZ              | Ą                     | ļ   |
| 9          | the   | 3a or  | Ö            | 30             | )10 Ceda                            | arcrest P                            | Avenue   |                  | 142 18/0                | Doceden                  | of Hisn       | anic Origi         | n? (Spec   | cify Yes or N        | No-                 | 14. Race         | - America             | n Indian, Black,                          |
|            | with  | ms 2   | era          |                | Marital Status                      | ied 2 Marrie                         | 12. Was Decedent 6 Armed Forces?                                     |                  | If Y                    | es, specify              | Cuban,        | Mexican,           | Puerto R   | ican, etc.)          |                     | White            | e, etc.               |   |
|            | deatl   | or ite   | Funeral      |                |                                     |                                      | Yes 2  | X No             | 1                       | Yes 2                    | No            | specify:           |            |                      |                     | Specify:         | Whit                  | e   |
|            | after   | al",   | 5            | 3              | Widowed                             |                                      | or Dates:  | pleted) 16       | o Docoder               | t's Usual O              | ccupatio      | on (Give k         | ind of wo  | rk done              | 16b.                | Kind of Bu       | siness/Ind            | ustry                                     |
|            | iours   | xam  | Completed by | 1:             |                                     |                                      | only highest grade com<br>College (1-4 or 5                          |                  | during m                | ost of work              | ing life.     | DO NOT I           | use retire | d)                   |                     |                  |                       |   |
| ď          | 721   | an ",  | et           | '              | Elementary/Sec                      | condary (0-12)                       | College (14 of c   | ~~               |                         | Prin                     | nter          |                    |            |                      |                     | Sign             | s                     |   |
| 5.0036     | within<br>ene.  | Ned th   | Ĕ            | 1              | 2 years                             | e (First, Middle, La                 | ot)  |                  |                         | 1111                     | 1             | 8.Mother           | s Name (   | First, Middle        | e, Maide            | n Surname        | *)                    |   |
| 7          | iled  | th da  | ပိ           | 17.            |                                     |                                      |  |                  |                         |                          | - 1           | Lil                | lian       | Mae (                | Caste               | el               |                       |   |
| 12         | d be lental   | arke   | ä            | P.             | hillp E                             | Carl Clar                            | (Type Print)   |                  | 19b. Mailin             | g Address                | (Street       | and Num            | ber or Ru  | ural Route N         | lumber,             | City or Tov      | vn, State,            | Zip Code)                                 |
| 2,0        | shoul<br>and N  | is m   | To           |                |                                     | J. Clark                             |  | l                | 3004                    | Ceda:                    | rcre          | st A               | venu       | e, Edg               | geme:               | re, M            | laryla                | and 21219                                 |
| 2          | nd 2  | raum   |              | 20             | a Method of Di                      | isposition                           |  | 20b. Pla         | ce of Dispo             | sition (Nam              | e of cen      | netery,            |            | Date<br>ruary        | 200                 | . Location       | - City of T           | OWII, State                               |
| 9          | es la<br>of He  | tant; If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once, or other traumatic event, |              | 1              | XBurial 2                           | Cremation                            | 3 Removal from St  | ate MO11         | matory or on the nt Ne. | bo Cei                   | mete          | ry                 |            | 2008                 | M                   | orgar            | ,West                 | t Virginia                                |
| Ì          | Page  | ant:   |              | 4              | Donation                            | 5 Other Spec                         | ify:   | Hou              |                         |                          |               |                    |            | ome O                | E Du                | ndalk            | - D :                 | Δ   |
| MD 0.00.00 | Daillillore, MID 414-1-2000  Bermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Denarturent of Health and Mental Hygiere.                      | npor   | '            | 1              | \ //                                | Funeral Service Lie                  | QVI  |                  | 17                      | 110 C                    | ~11~          | and D              | nt nt      | หดลต                 | . Du                | narı             | L , L'III .           | 21222                                     |
|            | n 8.0   | 2.5  | L            |                | XIM                                 | 2700                                 | implications that caused   | the death. D     | o not enter             | the mode of              | of dying,     | such as o          | cardiac or | respiratory          | arrest, s           | hock, or h       | eart                  | Approximate Interval<br>Between Onset and |
|            |   | ician<br>dical   |              | 23             | failure. List                       | only one cause or                    | each line.   |                  | 1.                      | -1                       | 11.           |                    | 1.         |                      | OWN                 | dono             |                       | Death                                     |
|            | _xan  |  |              | In             | nmediate Cause<br>r condition resu  | e (Final disease                     | a. Atheroscler   | COTIC CA         | raiova                  | <u>scular</u><br>xicatio | uise<br>on    | ase co             | Julian 10  | هسته                 | LAYLL               |                  |                       |   |
|            |   |  |              |                |                                     |                                      | b.   | ,                | HICO.                   |                          |               |                    |            |                      |                     |                  |                       |   |
|            |   |  | ı,           | S<br>if        | equentially list<br>any, leading to | ) immediate                          | Due to (or as a cons   | sequence of):    |                         |                          |               |                    |            |                      |                     |                  |                       |   |
|            |   |  | amine        | C<br>(I        | ause. Enter Ur<br>Disease or injur  | nderlying Cause<br>ry that initiated | C. Due to (or as a cons  | acarrence of):   |                         |                          |               |                    |            |                      |                     |                  |                       |   |
|            | -   | sit  |              | è              | vents resulting                     | in death) Last                       |  |                  |                         |                          |               |                    |            |                      |                     |                  |                       | <u> </u>                                  |
|            | ecute   | e attending physician and  | 1 3          | <u> </u>       | X UNPEND                            | -ED                                  | d.<br>x AMENDED #2   | 3a,27,28         | a-f, p                  | erME, g                  | 3 <u>76</u> , | 2/29/0             | 08 TT      |                      |                     |                  |                       |   |
|            | <b>60,</b><br>ate be ev   | siciar   | =            | Sician/Medical |                                     |                                      | 23c. If yes, outo  | perML, g         | 8/6, Z                  | /13/08                   | 11            |                    |            |                      |                     | 23d. Date        | of deliver            |   |
|            | 76<br>ficate  | g phy  | 1            | 23             | F FEMALE:<br>3b. Was decede         | ent pregnant in the                  |  | one or progra    |                         | Fetal death              | 3             | Ector              | oic pregna | ancy                 |                     | Month            | . [                   | Day Year                                  |
|            | certifica   | endin  |              | <u> </u>       | past 12 mor                         |                                      |  | at time of dea   | th 5                    | Other (Spe               | ecify)        |                    |            |                      | - 1                 |                  |                       |   |
| }          | Box<br>e death c  | the att  | , i          | <u>   </u>     | 1 Yes 2                             | No 9 Unkr                            | 5 Ollichom   |                  |                         | al a als dan             |               | given in l         | Part I     | 23e.                 | Did toba            | cco use co       | ntribute to           | the cause of death?                       |
|            | at the  | as been signed by the  |              |                | Part II. Other si                   | ignificant condition                 | ons contributing to de   | ath but not re   | sulting in th           | e underlyn               | ig cause      | givenini           | GIV II     |                      |                     |                  |                       | bably 4 Unknown                           |
|            | P.O   | signe  | 90 .         | Completed by   |                                     |                                      |  |                  |                         |                          |               |                    |            | 24a                  | Was an              | 24               | b. Were a             | utopsy findings available                 |
|            | requi   | been   |              | 왕              |                                     |                                      |  |                  |                         |                          |               |                    |            |                      | autopsy<br>performe |                  | prior to death?       | completion of cause of                    |
|            | S ≥ 8   | e has  | 8 7 as       | 티              |                                     |                                      |  |                  |                         |                          |               |                    |            |                      | Yes 2               | No               | 1 🗸 Y                 | es 2 No                                   |
|            | 8 ≒   | certificate  | r, page      |                | 25 Was case r                       | referred to medical                  |  |                  |                         |                          | 26.Pla        |                    |            | k only one)          |                     |                  |                       |   |
|            | ician<br>ician  | s cert   |              | صّا            | examiner?                           |                                      | Hospital: 1 Inpa   | atient 2         | ER/Outpat               | ent 3                    | DOA           | Other <sub>4</sub> | Nurs       | ing Home             |                     |                  | 6 🗸 Oth               | er: Scene                                 |
|            | Division of Vital Records, tal or Attending Physician: The law require  | er this  | Ta<br>Ta     | 라              | 1 ✓ Yes<br>27. Manner of I          | 2 No<br>Death                        | 28a. Date of 1   | njury            | 28b. Time               |                          |               | njury at W         |            | 28d. Des             | cribe ho            | w injury oc      | curred                |   |
|            | D O   | h.<br>After  | e funeral    | 5              | 1 Natura                            | 5 Pend                               |  |                  | FOUND:<br>1315 hrs      |                          | 1_            | Yes 2              | X No       | unk                  |                     |                  |                       |   |
|            | Sio   | r deat   | by th        | g              | 2 Accide                            | 0 37 0                               | Feb 3, 200<br>28e. Place o   | f Injury - At h  | ome, farm,              | street, facto            | ry, offic     | e building         | , etc.     | 28f. Loca            | ation (Str          | eet and Note ite | umber or F<br>CATTOWS | Rural Route Number, City<br>S Point, MD   |
|            | JY.   | s afte   | ed in        | Certification: | 3 Suicide                           | deter                                | rmined (Specify)   | other-           | scene                   |                          |               |                    |            | Unknow               | <del>n</del> 301    | <u>0 Ceda</u>    | rcrest                | Ave                                       |
|            | Division of Vital Records, P.O. Box 68760, the Hospital or Altending Physician: The law requires that the death certificate be executed to the Hospital or Altending Physician: | within 24 hours after death.  To the Funeral Director:   | y fil        |                | 4 Homic                             |                                      |  |                  |                         | ccurred at               | the time      | , date and         | place, a   | nd due to th         | e cause             | (s) and ma       | nner as st            | ated.<br>the cause(s)                     |
|            | the H   | hin 24<br>the F  | nplete       | Medical        | (Check only one) 2                  | ✓ Medical Exa                        | hysician: To the best of<br>miner:On the basis of<br>and manner stat | examination a    | nd/or inves             | tigation, in             | пу орт        | ion, deat.         |            | at the time          | ,                   |                  |                       | fonth, Day, Year)                         |
|            | ٩   | To   | con          | ĕ              | 29b. Signature                      | and title of certifie                |  |                  | 1                       |                          |               | ense num           | ber        |                      |                     | ∠9a. Date        | signed (A             | nunun, pay, real                          |
|            |   |  | -            |                | 1/                                  | /11-                                 | 11/1   | / 1              | / /                     |                          | Ο.            | C.M.E.             |            |                      |                     | ' 2/4/           | 2008                  |   |
| _          |   |  |              |                | 30 Name and                         | address of persor                    | who completed cause  | of death (Iter   | n 23a)                  |                          |               |                    |            |                      |                     |                  |                       |   |
|            |   |  |              |                | Assi                                | stant Medical                        | Examiner 111   | Penn Stre        | et, Baltın              | nore, ME                 | 2120          | )1                 |            |                      |                     |                  |                       |   |
|            |   |  | Si           | ate            |                                     | (Month Day Year)                     | 1.5  | istrar's Signa   | fre d                   | Section                  |               |                    |            |                      |                     |                  |                       |   |
|            |   | Re   |              |                |                                     | LEDIJ                                | 2000   |                  | 0                       |                          |               |                    |            | - 00                 | ME                  |                  |                       |   |

|                |   |                | 1- State of Ma  | ryland /           |                          | artment of F<br><i>rtificate of</i> .    |   | •                                   | giene<br>Reg. No. 2           | NΩ                     | 01.085  |
|----------------|---|----------------|---|--------------------|--------------------------|--|---|-------------------------------------|-------------------------------|------------------------|---|
|                | Db:   |                | Decedent's Name (First, Middle, Last)   |                    |                          |  |   | 2. Date of De<br>Month              | Same of                       | Year                   | 3. Time of Death                                  |
| 200            | Physici<br>/Medic   | al             | Alice V. Collin   | ns                 |                          | 41. C2. T                                | . I   | Februa                              | ry 11, 2                      | 2008                   | 9:50 A M  |
|                | Examin  | er             | 4a. Facility Name (If not institution, give street and number)  Brighton Gardens  |                    |                          | Rocky                                    | r Location of Death<br>7111e                            |                                     | 4c. County                    | or Death<br>gomer      | ·v  |
| -a             | Funeral   |                | 5. Social Security Number 6. Sex 7. Age   | e (In yrs. last bi | irthday)                 | If Under 1 Year<br>Months Days           | If Under 24 Hrs.<br>Hours Min.                          | 8. Date of Bir                      | th                            |                        | ace (State or Foreign<br>ry)                      |
|                | Director  |                | 030-12-0282 <sup>1□M 2⊠F</sup>  | 83                 | Yrs.                     | WOTHING Days                             | TIOUIS WIII.  |                                     | 14, 1924                      |                        | sachusetts  |
|                | land<br>ow  |                | Usual Residence of Decedent  10a. State 10b. County   | 10c. City, Tov     | wn or Lo                 | cation                                   |   |                                     |                               | 10                     | d. Inside City Limits                             |
|                | a-f sh  | ctor           | Maryland Montgomery   | Rock               | vil.                     | le                                       |   |                                     |                               |                        | 1 ☐ Yes 2 ☑ No                                    |
|                | /ith the  | Director       | 10e. Street and Number  |                    |                          | 10f. Zip Code                            |   |                                     | 10g. Citizen of V             | Vhat Count             | ry?   |
|                | eath v<br>IS 238<br>must  | Funeral        | 14241 Arbor Forest Drive, #   |                    | 13 1                     | 20850                                    |   | necify Yes or No                    | Unite                         | d Sta                  |   |
| 920            | urs after d<br>al", or item<br>Examiner   | þ              | Armed Forces?  1 Never Married 2 Married  1 Yes 2 X N  1 Yes, Give  2 Married Torces?   |                    |                          | f Yes, specify Cuba<br>1 ☐ Yes 2 🛣 No    | lispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | Rican, etc.)                        | Blac<br>Specify               | k, White, e            | etc.  |
| 215-0036       | be filed within 72 hours after death with the Maryland ntal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at  | Completed      | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-   | +)                 | (Give<br>life.           |  | during most of world)                                   |                                     | 16b. Kind of Bu               | siness/Ind             | ustry   |
| 2              | led wi<br>lygien<br>her th<br>nt, the   | Co             | 17. Father's Name (First, Middle, Last)   | Ai                 | rli                      | nes Repre                                | sentativ<br>18. Mother's Nam                            |                                     | Airl                          |                        |   |
| Maryland 2121  |   | o Be           | Waclav Golombiewski   |                    |                          |  |   | vzemska                             | , Malueri Surriani            | l <del>e</del> )       |   |
| ary            | 2 should be and Mental Is marked or raumatic eve  | 2              | 19a. Informant's Name/Relationship (Type. Print)  | 19                 | b. Mailir                | ng Address (Street                       | and Number or Ru  |                                     | er, City or Town,             | State, Zip             | Code)   |
| Σ.             | and 2<br>ealth a<br>n 27 l  |                | Mary E. Harding / Daughter  |                    |                          |  | st Drive, #   |                                     |                               |                        |   |
| altimore,      | permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic evonce.  |                | 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State  | cemet              | ery, crei                | sition (Name of<br>natory or other place |   | uary 19                             | 20c. Location -               | •                      |   |
| Itin           | nit. Pa<br>artmei<br>ortant<br>injury   | 1              | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee   | Arlingt            | 22                       | ational Ce<br>2. Name and Addre          | ss of Facility Ro                                       | 2008  <br>bert A.                   | Arlingt<br>Pumphre            | v Fun                  | eral Home/  |
| e<br>B         | Dep<br>Imp  |                |   | M01473             | R                        | ockville,<br>ockville,                   | Inc. 3<br>Marylan                                       | 00 West<br>d 20850                  | Montgom<br>-2805              | ery A                  | venue,  |
|                | Physician   |                | 23a. Part1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition Ather |                    |                          | c Heart D                                |   | or respiratory a                    | irest,                        |                        | Interval Between<br>Onset and Death               |
|                | /Medical<br>Examiner  |                | resulting in death)  Due to (or as a  | a consequence      | e of):                   |  |   |                                     |                               |                        | _   |
| 3              |   | -              |   | nic Lym            |                          | cytic Leu                                | kemia   |                                     |                               |                        |   |
|                | ansit   | Examiner       | rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Lype 1  | rtensio            | n                        |  |   |                                     |                               |                        |   |
| Ö,             | e exectian and urial-tr   | Exa            | resulting in death) Last Due to (or as a  | a consequence      |                          |  |   |                                     |                               |                        |   |
| 58760,         | ficate be executed physician and is the burial-transit  | edical         | d. <u>Demer</u>   | ntia               |                          |  |   |                                     |                               |                        |   |
| Box            | death certi<br>e attending<br>d for use a   | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ဩNo 9 □ Unknown  23c. If yes, outcome 1 1 □ Live birth 4 □ Pregnant at 9 □ Unknown             | 2 Fetal deat       |                          | ]Ectopic pregnanc<br>]Other (specify) _  | у   |                                     | 1                             | te of deliver          | ry<br>Day Year                                    |
| , P.O          | res that t<br>signed by<br>be detac   | by Ph          | Part II. Other significant conditions contributing to death but   | at not resulting   | in the u                 | nderlying cause giv                      | en in Part I.   | 23e. Did                            | tobacco use cont              | ribute to the          | e cause of death?                                 |
| ords           | w requires<br>been sign<br>should be  | ed b           |   |                    |                          |  |   | 10                                  | Yes 2 No                      | 3 ☐ Proba              | ably 4 Unknown                                    |
| Vital Records, | The la  | Completed      |   |                    |                          |  |   | 24a. Was<br>auto<br>perfo<br>1∐ Yes | psy<br>prmed?                 | prior to con<br>death? | osy findings available appletion of cause of 2 No |
| Vita           | iclan:<br>Sertific<br>ector,  | Be             | 25. Was case referred to medical examiner?  Hospital:   |                    |                          | t 3DDOA Oth                              | 26. Place of Dea  | th (Check only                      | one)                          |                        |   |
| Division or    | ding Phys<br>h.<br>After this<br>funeral dir  | tion: To       | 1 ☐ Yes 2 ☑ No  |                    | Outpatier  Time o Injury | f 28c. Inju                              | 4 X Nursing H   |                                     | dence 6 Oth                   |                        | )   |
| DIVISI         | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Trector After this certifica completely filled in by the funeral director, p.  | Certification: | a□ Cuiside 6□ Could not be  |                    | farm, str                | eet, factory, office                     |   |                                     | Street and Numb<br>wn, State) | er or Rural            | l Route Number,                                   |
|                | To the Hospit<br>within 24 hours<br>To the Funers<br>completely fille   | Medical (      | 29a. Certifier (Check only one)  1 X Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta  | f examination a    |                          |  |   |                                     |                               |                        |   |
|                | To the within To the complete | Ž              | 29b. Signature and title of certifier   |                    |                          | 29c. Licens                              |   |                                     | 29d. Date signe               |                        |   |
| )              | 2   |                |   |                    | ) /T                     | D536                                     | ) J T   |                                     | February                      | 11,                    | 2008  |
|                | 10  |                | 30. Name and address of erson who completed cause of de Ajay Reddy, M.D. 6320 Democ   |                    |                          |  | thesda. N   | Marvland                            | 1 20817                       |                        |   |
| i.             | Sta   | _              |   | ar's Signature     | Ana                      | elle )                                   |   |                                     |                               |                        |   |
|                | Registr   | ar             | I LUC A BOULD AND AND AND AND AND AND AND AND AND AN  | STEET A            | No.                      | 160                                      |   |                                     |                               |                        |   |

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|  |              | 1               | For<br>State<br>Registrar   |  | State of Ma  | aryland /                         | -                             | rtificate                                       |                    |                               |                        | F                                    | Reg. No.    | 20                   | 0.8   | 040                                       | 86                   |
|--|--------------|-----------------|---|--|--|-----------------------------------|-------------------------------|---|--------------------|-------------------------------|------------------------|--------------------------------------|-------------|----------------------|---|---|----------------------|
| Phys   | siciar       |                 | . Decedent's Name   |  |  |                                   |                               |   |                    |                               | 2                      | . Date of Dea<br>Month               | Day         | _                    | Year  | 3. Time of 5:5(                           | Death<br>PM/         |
| /Me  | edica        |                 | Constance   |  |  |                                   |                               | 4b. City. To                                    | wn. or L           | ocation of E                  | Death                  | Febru                                |             | <u> </u>             | 2008<br>of Death                              | 3.30                                      |                      |
| Exa  | mine         | 4               | Holy Cro  |  |  |                                   |                               |   |                    | Silve                         |                        | ring                                 | М           | onto                 | jomer   | У   |                      |
| Fune<br>Direct   |              |                 | . Social Security Nur<br>146-28-3   | 598                                      | ex   | je (In yrs. last<br>72            | birthday)<br>Yrs.             | If Under 1 Months D                             |                    | If Under 24                   |                        | Date of Birt<br>(Month, Day<br>06/12 | , Year)     | 5                    | 9. Birthp<br>Coun<br><b>NJ</b>                | lace (State of<br>try)                    | Foreign              |
| and w  |              |                 | Jsual Residence of D  | ecedent<br>10b. County                   |  | 10c. City, To                     | own or Lo                     | ocation   |                    |                               |                        |                                      |             |                      | 1   | 0d. Inside Cit                            | y Limits             |
| Maryla<br>f sho  |              |                 | MD  | Montgor                                  | nerv   | Silv                              | ver S                         | Spring  |                    |                               |                        |                                      |             |                      |   | 1 □Yes                                    | 2 <b>⊠</b> No        |
| r 28a-   |              |                 | Oe. Street and Numb   |  |  |                                   |                               | 10f. Zip Co                                     | ode                |                               |                        |                                      | 10g. Citiz  | en of W              | hat Cour                                      | try?                                      |                      |
| th witl<br>23a o<br>ust be   |              | 2               | 9605 Bris   | stol Ave                                 |  |                                   |                               | 209   | 01-                |                               |                        |                                      | USF         |                      |   |   |                      |
| Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or Items 23a or 28a-f show any Injury or putter traumatic event, the Medical Examiner must be notified at   | L            | by rur          | I1. Marital Status 1 □ Never Marrie 3 □ Widowed 4   |  | 12. Was Decedent<br>Armed Forces?<br>1 ☐ Yes 2 ☑<br>If Yes, Give<br>Year or Dates: | ,                                 |                               | Was Deceder<br>If Yes, specify<br>1 ☐ Yes 22    |                    |                               | n? (Speci<br>Puerto Ri | fy Yes or No-<br>can, etc.)          |             |                      | k, White,                                     |   |                      |
| 5-0<br>72 hc<br>72 hc<br>inatui  |              | eleo            | (Specif   | 15. Decedent's Ed<br>y only highest gra  | ucation<br>de completed)   | 1                                 | 6a. Dece<br>(Give             | dent's Usual 0<br>kind of work of<br>DO NOT use | Occupat<br>done du | tion<br>uring most o          | f working              | ,                                    |             |                      | siness/Inc                                    | dustry                                    |                      |
| 121<br>vithin<br>sne.<br>than "  |              | Completed       | Elementary/Second   | dary (0-12)                              | College (1-4or   | · I                               | writ                          |   | retirea)           |                               |                        |                                      | rre         | зе г                 | ance  |   |                      |
| d 2  |              |                 | 17. Father's Name (F  | First, Middle, Last)                     |  | 5+                                | WIIC                          | .er   | 1                  | 18. Mother's                  | Name (                 | First, Middle,                       | Maiden      | Surnam               | e)  |   |                      |
| ld be ental ked o  |              | 0 De            | Henry H   |  |  |                                   |                               |   |                    | Wilma                         | a Ri                   | neinbol                              | t           |                      |   |   |                      |
| Maryland d 2 should be file th and Mental Hy 77 Is marked oth  |              |                 | 19a. Informant's Nan  | ne/Relationship (                        | Type. Print)   | 1                                 | 19b. Maili                    | ng Address (S                                   | treet ar           | nd Number                     | or Rural               | Route Numb                           | er, City or | Town,                | State, Zip                                    | Code)                                     |                      |
| ore, Ma<br>stand 2<br>of Health a<br>item 27 Is  |              |                 | Daniel B  | . Davis/H                                | usband   |                                   |                               | 5 Bris  |                    | Ave S                         |                        |                                      |             |                      |   |   |                      |
| Baltimore, bermit. Pages 1 ar Department of Hea Important: If item   | in a single  |                 | 4 □ Donation 5  | Cremation 3<br>5 Other (Specify          |  | Che                               | etery, cre<br>sape            | osition (Name<br>ematory or other<br>ake Cre    | er place,<br>emat  | ory                           |                        | eb 8<br>008                          |             |                      | •   | wn, State<br>Maryla                       | nd                   |
| Departiment Import   | once.        |                 | 21. Signature of Fun  | 4 Dold                                   | man  | 100382                            |                               | 2. Name and A<br>Rapp Fu<br>933 Gis             | nera               | al & C<br>ve. S               | ilve                   | r Sprin                              | g, Ma       | es<br>aryl           | and 2   | 0910-                                     |                      |
| 68760, tificate be executed Examination and set the burial-ransit  | cal<br>ner   | edicai Examiner | 23a. Pant1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)  Sequentially list condition in death, leading to minimal to make the cause. Enter Under Cause (Disease or in that initiated events resulting in death) Leading in death) Leading in death) Leading in death, or cause (Disease or in the cause). | ditions, neurale ying ajury              | b. Out to (or as   | d the death. I ine.               | Can<br>nice of):<br>Nice of): | ner the mode of                                 |                    |                               | ardiac or              | respiratory a                        | rrest,      |                      |   | Approximate Interval Bet Onset and It Man | ths_                 |
| ords, P.O. Box 68 requires that the death certificate eer signed by the attending phontid he detached for use as the   | ő .          | Pnysician/Med   | IF FEMALE: 23b. Was decedent in the past 12, 1 □ Yes 2, 9 □ Unknown   | nonths?                                  | 23c. If yes, outcome<br>1 □ Live birth<br>4 □ Pregnant a<br>9 □ Unknown            | 2 ☐ Fetal de                      | eath 3                        | □Ectopic prec<br>□ Other (spec                  |                    |                               |                        |                                      | 2           |                      | e of deliventh                                |   | Year                 |
| cords, P. w requires that been signed by   | B .          | 2               | Part II. Other signific   | Clartry                                  | · (1)  | but not resultin                  | $-(\lambda)$                  |   | se giver           | n in Part I.                  |                        | 23e. Did t                           |             | se conti<br>⊒ No     |   | he cause of coably 4 □1                   |                      |
| Pec law has b  | nage z snou  | Completed       | Diabetes  | Melle                                    | tus Typ  | ec 2 1                            |                               |   |                    |                               |                        | 24a. Was<br>auto<br>perfo            |             |                      | Were auto<br>prior to co<br>death?<br>I □ Yes | ppsy findings<br>impletion of c           | available<br>ause of |
| Vital F sician: Th certificate   | d 101, p     | O               | 25. Was case referre  | ed to medical                            |  |                                   |                               |   |                    | 26. Place o                   | f Death                | (Check only                          |             |                      |   |   |                      |
| in or Vita<br>ing Physician;<br>After this certific  | ō.           | on: lo B        | examiner? 1 ☐ Yes 2 2 1 1 27. Manner of Death 1 Natural   | 5 Pending                                | 28a. Date of Inj<br>(Month, Da   |                                   | NOutpatie  Bb. Time Injury    | of 280  | : Injury<br>Work   | at ?                          | 28                     | e 5 Resi                             |             |                      |   | fy)                                       |                      |
| Division of To the Hospital or Attending Physicial 24 hours after death.  To the Funeral Director: After Americal Director: Attending the Americal Directors and Americal Directors and American Directors and American Directors and American Directors and American Directors and Direct | a III by the | Certification:  | 2 ☐ Accident<br>3 ☐ Suicide<br>4 ☐ Homicide   | investigation 6  Could not be determined | e 28e. Place of in   | njury - At home<br>etc. (Specify) | e, farm, s                    | M treet, factory,                               |                    | ∕es 2∐No                      |                        | Bf. Location (<br>City or To         |             |                      | er or Run                                     | al Route Nun                              | nber,                |
| e Hospital 24 hours e Funeral  | retery tille | Medical C       | 29a. Certifier<br>(Check only<br>one)   | 1 × ertifying Pł<br>2 ☐ Medical Exa      | nysician: To the best<br>miner: On the basis<br>and manner s                       | of examination                    | edge, dea<br>n and/or i       | ath occurred at<br>investigation, i             | the tim            | ne, date and<br>pinion, death | place, a<br>occurre    | nd due to the<br>d at the time       | cause(s)    | ) and ma<br>d place, | anner as s<br>and due t                       | stated.<br>to the cause(                  | s)                   |
| To the To the To the   | Comp         | Me              | 29b. Signature and t  | title of certifier                       |  |                                   |                               |   |                    | number                        |                        |                                      |             |                      |   | Day, Year)                                |                      |
|  | 7            |                 | Barlo   | era Sc                                   | eparisch   | pem.                              | M                             |   | 06                 | ,548                          | 35                     |                                      |             | 2/                   | 6/2   | 008                                       |                      |
| 97   | 6            | 1               | 30. Name and addre  | ess of person who                        | o impleted cause of  |                                   |                               |   |                    | 0                             |                        |                                      | 2           |                      |   | 2   | 20910                |
| $\alpha u$   |              |                 | BARBARA   |  |  | HCF                               | 4,                            | 1500 F  | ORE                | 57 Gic                        | ENL                    | n S                                  | ULUB        | RAI                  | PRIN  | 4 MI                                      | 5                    |
| Po   | Stat         |                 | 31. Date filed (Monti   |  | 322Regist  | t/ar's Signatur                   | е                             | ack!  |                    |                               |                        |                                      |             |                      |   |   |                      |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2008 03 **Physician** PM Davis James /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore Pikesvile Jewish Convalescent Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 06 23 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Hours **X**□M 2□ F Months Days ٧A Director 219-01-1896 Usual Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show other traumatic event, the Medical Examiner must be notified at 1 ¥ Yes 2 No Baltimore NA Director MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 5 With U.S.A. 21215 5544 Nome Ave 238 Funeral Pages 1 and 2 should be filed within 72 hours after death nend of Heath and Mental Hygiene.

ant: If Item 27 Is marked other than "natural; or Items 23 array or other traumatic event, it is Medical Example near nust 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Be Completed by Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodial Engineer Baltimore City 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bertha Davis George Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5544 Nome Ave. Baltimore, Md 21215 19a. Informant's Name/Relationship (Type, Print) 5544 Nome Ave, Baltimore, Md Alma Davis-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Baltimore Co, Md 2/13/08 Woodlawn Funeral Service 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore, 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immeriate Cause (Final diserse or condition ulting in death) **Physician** lung carrier 6 m cally /Medical Due to (or a a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Ay pue The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year þ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) P.0 detached 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Waknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 🗆 Yes 2[ of Vital To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 To 2000 1 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide within 24 hours a To the Funeral L filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W Betwelore are h 2436 31. Date liled (Month, Day, Year) 32 degistrar's Signature State FEB 13 2008 Registrar

|  |                      | For State Registrar  1. Decedent's Name (First, Middle, Last)  | Ce  | rtificate of Death   |  | Reg. No. 200                                       |   |
|--|----------------------|--|---|--|--|--|---|
| hysic  |                      | Eleanor Marlene Enslow   |   |  | 2. Date of Dea<br>Month<br>Februar       | ath<br>Cy 09, 200                                  | 3. Time of Death 12:15 A.   |
| /Medi<br>Examir  |                      | 4a. Facility Name (If not institution, give street and number<br>Stella Maris Hospice  | er)   | 4b. City, Town, or Location of De  |  | 4c. County of De                                   |   |
| ineral<br>rector   |                      | 216-26-1427 ¹□M 2ÅF  | Age ( <i>In yrs. last birthday</i> )<br>74 Yrs. | If Under 1 Year If Under 24 H<br>Months Days Hours Mi                                      |  | 9. B<br>(1933 Ba                                   | irthplace (State or Foreig<br>Country)<br>1 clinore, MD.            |
| a-f show<br>fied at  | tor                  | Usual Residence of Decedent  10a. State 10b. County  Maryland Anne Arundel Co.   | 10c. City, Town or Lo                           |  |  |  | 10d. Inside City Limi   |
| 23a or 28<br>st be not   | Funeral Director     | 10e Street and Number<br>582 Terrace View Ave.   |   | 10f. Zip Code 21225  |  | 10g. Citizen of What C<br>United St                |   |
| If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the <u>Medical Examiner must be notified at</u>  | þ                    | 11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decede Armed Force 1 Yes 25 If Yes, Give Year or Date: | s?<br>[] No                                     | Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu  1 ☐ Yes 2 No Specify: | (Specify Yes or No-<br>erto Rican, etc.) | 14. Race - An<br>Black, Wh<br>Specify:             | nerican Indian,<br>nite, etc.<br>White                              |
| an "natur<br>Medical I   | Completed            | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4c)  | (Give   | dent's Usual Occupation<br>kind of work done during most of v<br>DO NOT use retired)       | working                                  | 16b. Kind of Busines                               | s/Industry  |
| other th   | Be Con               | 12 n/a 17. Father's Name ( <i>First, Middle, Last</i> )  | Home  | e Health Care Nur<br>18. Mother's N  | CSE Name (First, Middle,                 | Nursing  Maiden Surname)                           | Care  |
| narked<br>natic ev   | To B                 | George E. Altevogt  19a. Informant's Name/Relationship (Type. Print)   | 10h Maili                                       |  | May Bell                                 | 011 7 011  |   |
| m 27 ls i<br>ner traui   |                      | Mrs. Michelle M. Clary (Gra  | and Dau.) 5                                     | ng Address (Street and Number or<br>322 Patrick Henr                                       | ry Drive                                 |  |   |
| Important: If item 27 Is marked other than any Injury or other traumatic event, the Me once.   |                      | 20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta  4 ☐ Donation 5 ☐ Other (Specify)  | te Evans Fun                                    | osition (Name of<br>matory or other place)<br>neral Chapel Fek                             | Date 7 • 14.2008                         | 20c. Location - City of Forest                     | orTown,State<br>Hill, Mary  |
| Importa<br>any Inju<br>once.   |                      | 21. Signature of Funeral Service Licensee  |   | 2. Name and Address of Facility<br>caceful Alternati<br>2325 York Road                     |  |  | ion Ctr.,P.   |
| hysician and chicago is the burlal-transit chicago is the burlal-t | Examiner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events                              | as a consequence of):  as a consequence of):    | ter the mode of dying, such as card  | flac or respiratory an                   | rest,  | Approximate<br>Interval Between<br>Onset and Death                  |
| gned by the attending p<br>be detached for use as t  | by Physician/Medical |  | 2 Fetal death 3 at time of death 5              | □Ectopic pregnancy □ Other (specify)   | 23e. Did to                              | 23d. Date of d<br>Month                            | letivery Day Year to the cause of death?                            |
| artificate has been si<br>ctor, page 2 should t  | Completed            |  |   |  | 24a. Was a                               | an 24b. Were prior to death'                       | Probably 4 Nunkno autopsy findings availal o completion of cause of |
| fter this ce<br>neral dire   | Certification: To Be | 2 Accident investigation   | njury 28b. Time o<br>Day Year) Injury           | ont 3 DOA Other: 4 Nursing  of 28c. Injury at Work?  M 1 Yes 2 No                          | 28d. Describe h                          | lence 6 <b>X</b> 10ther (Sp<br>now injury occurred | pecify) HOSPICE   |
| To the Funeral Director: A completely filled in by the fu  |                      | 4 Homicide determined 200. Place of building,  | injury - At home, farm, sti<br>etc. (Specify)   |  | City or Tow                              |  |   |
| mpletely f   | Medical              | 29a. Certifier (Check only one)  1 ★ Certifying Physician: To the be 2 ★ Medical Examiner: On the basis and manner  29b. Signature are title of certifier      | of examination and/or in                        | th occurred at the time, date and planvestigation, in my opinion, death of                 | ccurred at the time,                     | date and place, and d                              | ue to the cause(s)  |
| <b>2</b> 8   | -                    | 290. Signature age title of cermier  | 2   | 29c. License number  |  | 29d. Date signed (Mo.                              | nth, Day, Year)   |
| 1  |                      | 30. Name and address of person who completed cause o   |   |  |  |  |   |

DHMH 17 Rev 1/2001

FEBRUARY 9, 2008 12:15 a.m.

ELEANOR ENSLOW

ORIGINAL

10

To the within 2.

> State Registrar

1302

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

9901 Medical Center Drive, Rockville, Maryland 20850 2. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month February 8, Phyllis Eileen Fugate 2008 8:05PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14212 Brad Drive Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Months Days Hours 89 Director February 22, 1918 068-16-5933 New York Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14212 Brad Drive 20853 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 2 X No 1 ☐ Yes 2 ☑ No Specify. Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natu any Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MarylandStateDepartment of Agriculture Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Fay H. Barbour Emma Drake 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia F. Borgoyn/ Daughter 1451 Pleasantville Drive Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State February 11, 2008 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral flome/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M00335 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be execution burial-transit Cause (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): physician the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) led by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Breast Cancer 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hypertension 24a. Was an Was a... autopsy performed? Yes 2X No certificate has 1∐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Hospital or Attending 1 X Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide 24 hours a Euneral I 29a, Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l within 2 29c. License number 29b. Signature, and title of certifier 29d. Date signed (Month, Day, Year) D67162 February 11, 2008

Registrar DHMH 17 Rev 1/2001

State

6

Maryland 21215-0036

altimore,

Division or Vital Records, P.O. Box 68760,

15225 Shady Grove Road #203, Rockville, Maryland 20850-3284

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Martin W. Graf, M.D

3

31. Date filed (Month, Day, Year)

FEB 1

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| Edward Flaim, Jr.  | R              | paietrar  |  | and /<br><b>xer</b> f   | Department                                    | of He                 | ealth and<br><b>/08dhb</b>             | d Menta                     | al Hygi                    | ene<br>Reg.                        | No. 200                                 | 8 040                                      |  |  |
|--|----------------|---|--|-------------------------|---|-----------------------|--|-----------------------------|----------------------------|------------------------------------|---|--|--|--|
| Physician<br>Medical Examine   | 7              | I. Decedent's Name (First, Midd   |  | uis                     | Flaim, Jr                                     |                       |  |                             | I 1                        | Date of Death  Month D  ebruary 6, | Day Year<br>2008 ·                      | 3. Time of Death<br>0215 hrs               |  |  |
| ( )  |                | a. Facility Name (if not institution 5919 Rolston Road  |  |                         |   | 4b. C                 | City, Town, or lethesda                | Location of                 |                            |                                    | 4c. County of Dea<br>Montgomery         | th   |  |  |
| Funeral  |                | 5. Social Security Number   | 6. Sex   |                         | (In yrs. last birthday)                       | If                    | Under 1 Year                           |                             | 24Hrs. 8.                  | . Date of Birth(                   | MM/DD/YYYY) 9. B                        | irthplace (State or<br>eign Washingto      |  |  |
| Director   |                | 218-56-2975 Usual Residence of Decedent   | 1X M 2 F   | 57                      | -58-  | Yrs. Febru            |  |                             |                            |                                    | 19,1950 °                               | D.C.                                       |  |  |
| v any  |                | 10a. State 10b. County  |  | ľ                       | 10c. City, Town or Lo                         | cation                |  |                             |                            |                                    |   | 10d. Inside City Limits 1 Yes 2 X No       |  |  |
| yland<br>a-f shov  |                | Maryland Mo   | ontgomery  |                         | Bethesda<br>10f. Zip Code                     |                       |  |                             |                            | 10g                                | ountry?                                 |  |  |  |
| the Maryland a or 28a-f sh   |                |   | Rolston  | Road                    | i   |                       |  | 2081                        | 7                          |                                    |   | d States                                   |  |  |
| ath with items 23  | Funeral        | 11. Marital Status 1 Never Married 2 N  | farried Armed  | Forces?                 |   |                       | ecedent of His<br>specify Cuban        |                             |                            |                                    | 14. Race - Am<br>White, etc.            | erican Indian, Black,                      |  |  |
| after des all', or i   | 6<br>2         |   | vorced If Yes, Give Yor Dates:   | eer                     | X No 1  |                       | s 2 X No                               |                             |                            |                                    | Specify:                                | White                                      |  |  |
| 2 hours  |                | 15. Decedent's Education (Spe<br>Elementary/Secondary (0-12)  |  | ade comp<br>(1-4 or 5   | durin   |                       | Jsual Occupat<br>of working life.      |                             |                            |                                    | 6b. Kind of Busines                     | s/industry                                 |  |  |
| 0036<br>within 7<br>giene.<br>ner than<br>Medica   | Completed      | 17. Father's Name (First, Middle  |  | +                       |   | At                    | torney                                 |                             |                            | rst. Middle. Ma                    | Self I                                  | Employed                                   |  |  |
| 우리 발표를 다   | ů<br>n         | Edwar   | d Lewis F  | laim'                   | ı, Sr.  |                       |  |                             | Jo                         | hanna (                            | Clara Sak                               | se   |  |  |
| MD 21 d 2 should lth and Me n 27 is ma aumatic ex  | 2 [            | 19a. Informant's Name/Relation Sean Michael   |  | lon                     | i   |                       |  |                             |                            | ver Sp:                            | er, City or Town, Starring, Mar         | yland 20906                                |  |  |
| re, N<br>s 1 and 2<br>f Health<br>If item 2  | Ī              | 20a. Method of Disposition  1 Burial 2 X Cremation  |  |                         | 20b. Place of Dis                             | position              | n (Name of cer                         | metery,                     | D                          | ate                                | 20c. Location - City                    | or Town, State                             |  |  |
| Baltimore,<br>pernit. Pages I ar<br>Departant of Her<br>Important: If ite<br>injury or other tr            | ļ              | 4 Donation 5 Other S<br>21. Signature of Euneral Service  | Specify:   |                         |   |                       |  | s of Facility               | 12,<br>Rober               | uary<br>2008<br>t A. Pi            | Bethesd<br>umphrey F                    | a, Maryland<br>uneral Home                 |  |  |
| Ba<br>perm<br>Depa<br>Imp  |                |   | ) To she   | 1                       | м00335  | eth<br>eth            | esda-C<br>esda,                        | hevy<br>Maryl               | Chase<br>and 2             | 08 <sup>1</sup> 4 <sup>2</sup> 3   | 501 W1s                                 | uneral Home<br>consin Aven                 |  |  |
| Physician // /Medical  |                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause the reach line. |  |                         |   |                       |  |                             |                            |                                    |   |  |  |  |
| Examiner   |                | or condition resulting in death)  Due to (or as a consequence of):  |  |                         |   |                       |  |                             |                            |                                    |   |  |  |  |
|  | <u>ا</u> ق     | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  |  |                         |   |                       |  |                             |                            |                                    |   |  |  |  |
| ed A sit   | Examiner       | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  |  |                         |   |                       |  |                             |                            |                                    |   |  |  |  |
| recul  | edical         | d. UNPENDED AMENDED   |  |                         |   |                       |  |                             |                            |                                    |   |  |  |  |
|  | J/Me           | IF FEMALE:<br>23b. Was decedent pregnant in   | the Common of th | s, outcom               | ne of pregnancy                               | Fetal                 | death 3                                | Ectopic                     | pregnanc                   | у                                  | 23d. Date of deliv                      | very<br>Day Year                           |  |  |
| Box 6: a death cert the attending ed for use a   | /sician/M      | past 12 months?  1 Yes 2 No 9 U   | det det  | egnant at<br>h<br>known |   | Other                 | (Specify)                              |                             |                            |                                    |   |  |  |  |
| d by   | by Phy         | Part II. Other significant cond   |  | g to death              | n but not resulting in                        | the unde              | erlying cause                          | given in Pa                 | art I.                     |                                    |   | to the cause of death?  Probably 4 Unknown |  |  |
| ds, P. equires the enem signe ould be de   |                |   |  | _                       |   |                       |  |                             | _                          | 24a. Was a                         | n 24b. Were                             | autopsy findings availat                   |  |  |
| Records, The law require ficate has been si, page 2 should b   | Completed      |   |  |                         |   |                       |  |                             |                            | autops<br>perforr<br>1  Yes 2      | ned? death                              | 1?   |  |  |
| Vital Recomposition: The later this certificate hald director, page 2                                      | B B            | 25. Was case referred to medic examiner?  | Hospital:  | Inpatie                 | ent 2 ER/Outpa                                | tient 3               |  | e of Death                  | (Check onl                 | -                                  | Residence 6 🗸 O                         | ther: Scene                                |  |  |
| n of Vital ing Physician: After this certif  | 일              | 1 Yes 2 No<br>27. Manner of Death   | 28a. Da  | ate of Inju             | ıry 28b. Time                                 | of Inju               | ry 28c. Inju                           | ıry at Work                 | ? 28<br>Si                 |                                    | ow injury occurred                      |  |  |  |
| Division (a) or Attendiu rs after death. a) Director: A led in by the fi                                   | Certification: | 2 Accident Inv  | estigation 28e P   |                         | 0150 hr                                       |                       |  | Yes 2 ✓<br>building, et     |                            |                                    |   | Rural Route Number, C                      |  |  |
| Div<br>pital or<br>ours afte<br>neral Dia  | er E           | 4 Homicide  |  |                         | igle Family Hom                               |                       |  |                             | -                          |                                    | Road, Bethesda, I                       |  |  |  |
| Division of  To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After 1 | edical         | 29a. Certifier 1 Certifying (Check only 2 Medical Ex  | Physician: To the last<br>caminer:On the base<br>and manner  | is of exa               | y knowledge, death o<br>mination and/or inves | occurred<br>stigation | d at the time, on<br>the in my opinion | tate and pla<br>n, death oc | ace, and du<br>curred at t | ue to the cause<br>he time, date a | e(s) and manner as and place, and due t | o the cause(s)                             |  |  |
| To with To con   | We             | 29b. Signature and title of certif  |  | Stateu.                 |   |                       |  | se number<br>.M.E.          |                            |                                    | 29d. Date signed (February 6, 20        |  |  |  |
| <b>→</b> 4   |                | 30. Name and address of person  | on who completed o   | ause of d               | death (Item 23a)                              |                       |  | <del></del> -               |                            |                                    |   |  |  |  |
|  |                |   | Assistant Medi   | cal Exa                 | aminer 111 P                                  | enn S                 | treet, Balti                           | more, M                     | ID 21201                   | 1                                  |   |  |  |  |
| Sta<br>Registr   |                | FEB 1 3   | 2000 1200  | Kegisti a               | All Alle                                      | out                   | 1                                      |                             |                            |                                    |   | · · · · · · · · · · · · · · · · · · ·      |  |  |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Physician Leroy Gran 23:40 Koger FEBRUARY 8 2008 /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 125M 2□F 218-60-1428 November 6, 1953 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 XYes 2 No Director Maryland Allegany Ellerslie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 3 must be n Ellerslie Rd 21529 USA 1412 . N. W Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: 14. Race - American Indian, items 11. Marital Status "natural", or item edical Examiner Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify White ģ 3 □Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineering Firm Laser Engineer ortant: If item 27 is marked other injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hiliga Lowery Kenneth ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ritten House Rd. Stockton, NJ 08559 Brenda Demarest 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry February 10,2008 Hanover 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Drive Suite P. Hanover 21. Signature of Funeral Service Licensee MD21076 23a. Part1. Enter the disease, or complications in at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SDAYS Physician disease or condition resulting in death) ARRUTHO /Medical Due to (or as a consequence of): Examiner JOONARI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Hlnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown SYNDROME Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? res 2. No death? 1 ☐ Yes 2 ☐ No DIABETES ellites 25. Was case referred to medical examiner? 26. Place of Death Check onl- one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

24 hours after death • Funeral Director: Medical within 24

> State Registrar

29a. Certifier

29b. Signature and title of certifier

ROBERT WELIK, MD

31. Date filed (Month, Day, Year)

100502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

904

DHMH 17 Rev 1/2001

32. Registrar's Signature

SETON DRIVE, CUMBERLAND, MD

29c. License number

21502

29d. Date signed (Month, Day, Year)

|   |   |                | For State Registrar   | e of Marylar                                    |                          | ertment of H   |                            | nd Mental Hy                                  | giene<br>Reg. No. | 711118  | 04093                           |
|---|---|----------------|---|---|--------------------------|--|----------------------------|---|-------------------|---|---------------------------------|
|   | - 60  | 14             | Decedent's Name (First, Middle, Last)   |   |                          |  |                            | 2. Date of De                                 | ath               |   | 3. Time of Death                |
|   | Physicia<br>/Medic  | _              | Ethel P. Gibbo  | ns  |                          |  |                            | Feb. 6  | , 20              |   | 11:50 P <sup>M</sup>            |
|   | Examin  | -48            | 4a. Facility Name (If not institution, give street at   | nd number)                                      |                          | 4b. City, Town, or   | Location of                | Death   | 4c.               | County of Death   |                                 |
|   |   | - 4            | Stella Maris  |   |                          | Timoniu  |                            | 411-  |                   | Balti   |                                 |
|   | Funeral   |                | 5. Social Security Number 6. Sex  | 7. Age (In yrs.                                 | last birthday)<br>7 Yrs. | If Under 1 Year<br>Months Days   | If Under 2                 | Min. (Month, Da                               | y, Year)          | Coui  |                                 |
|   | Director  |                | Usual Residence of Decedent   |   |                          |  |                            | Dec. 3  | , 19              | 20 <u>Ma</u>  | ryland                          |
|   | /land<br>ow<br>at   |                | 10a. State 10b. County  | 10c. Ci   | ty, Town or Lo           | cation   |                            |   |                   |   | 10d. Inside City Limits         |
|   | a-f sh<br>ified   | io             | MD Baltimore  | P   | arkton                   |  |                            |   |                   |   | 1 ☐ Yes 2X No                   |
|   | or 28.  | Director       | 10e. Street and Number  |   |                          | 10f. Zip Code  |                            |   | 10g. Citi         | izen of What Cou  | ntry?                           |
| M   | ath wi  |                | 16924 Fickerwood Roa  |   |                          | 2112   |                            |   |                   | USA   |                                 |
| P.  | tems  | Funeral        | Arm   | Decedent Ever in U                              | .S. 13.                  | Was Decedent of Hi<br>f Yes, specify Cuba  | spanic Orig<br>n, Mexican, | in? (Specify Yes or No<br>Puerto Rican, etc.) | -                 | <ol> <li>Race - America</li> <li>Black, White,</li> </ol> |                                 |
| 36  | rs afte   | by F           | If Yo   | Yes 2∭ No<br>es, Give<br>r or Dates:            |                          | 1 ☐ Yes 2 <b>X</b> No  | Specify:                   |   |                   | Specify: Whit   | e                               |
| 11:50<br><b>5-0036</b>                    | thour<br>atural   |                | 15. Decedent's Education  |   | 16a. Dece                | dent's Usual Occupa  | ation                      |   | 16b. Ki           | ind of Business/In  | ndustry                         |
| . 215                                     | hin 72<br>nn "ng<br>Medi  | plet           | (Specify only highest grade composition (Specify only highest grade composition)  Elementary/Secondary (0-12)  Coll | eted)<br>ege (1-4or 5+)                         | (Give<br>life. I         | kind of work done of<br>OO NOT use retired   | luring most<br>)           | of working                                    |                   |   |                                 |
| 2121                                      | d with  | Completed      | 12  | N/A   | Но                       | memaker  |                            |   |                   | Own Ho  | ome                             |
|   | be file<br>tal Hy<br>d oth  | Be (           | 17. Father's Name (First, Middle, Last)   |   |                          |  |                            | 's Name (First, Middle,                       | , Maiden          | Surname)  |                                 |
| -   | ould<br>Men<br>arke   | 욘              | Leroy Boll  |   | 1                        |  |                            | adys Neal                                     |                   |   |                                 |
| 6,<br>Mary                                | 12 sh<br>h and<br>7 is m<br>traum   |                | 19a. Informant's Name/Relationship (Type. Prir  | it)   |                          |  |                            | r or Rural Route Numb<br>Road Parkt           | -                 |   | •                               |
|   | iges 1 and 2 should be filed within 72 hours after death with the Maryland<br>to of Health and Mental Hyglene.<br>If item 27 is marked other than "natural", or items 23a or 28a-f show<br>or other traumatic event, the Medical Examiner must be notified at |                | Bradley Gibbons/Son  20a. Method of Disposition   | 20b.  | Place of Disno           | sition (Name of  |                            |   |                   | ocation - City or T                                       |                                 |
| FEBRUARY Baltimore,                       | permit. Pages 1 Department of H Important: If ite any Injury or ot  |                | 1 X Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)   | from State Pa                                   |                          | natory or other plac   |                            | eb. 12,<br>2008                               |                   | Parkv <b>i</b> 1  | 1 <sub>e</sub> MD               |
| EBF<br>Iltir                              | nit. P<br>artme<br>ortan<br>Injur   |                | 21. Signature of Funeral Carrice Liceasee   |   |                          | metery<br>2. Name and Addres   |                            | ome of Dul                                    |                   |   |                                 |
| Ba  | permit. Pages 1 and 2 s<br>Department of Health ar<br>Important: If item 27 is<br>any Injury or other trau  |                | Peli  | Flagle  | 1                        | mmon Fune<br>O W. Pado   | raı H<br>nia R             | ome of Dul<br>oad Timoni                      | aney<br>um,       | valley,<br>MD 21093                                       | inc.                            |
|   |   |                | 23a Fart1 Enter the disease, or complications shock, or heart failure. List only one caus                           | that caused the dea                             | th. Do not ent           | er the mode of dyin  |                            | ardiac or respiratory a                       |                   |   | Approximate<br>Interval Between |
|   | Physician   | 2. 14          | Immediate Cause (Final disease or condition   | Chre  | NIC                      | disse  | 9                          | 1155012                                       | -                 |   | Onset and Death                 |
| 4   | /Medical  |                | resulting in death)   | ue to (or as a consec                           | quence of):              | -  |                            |   |                   |   |                                 |
|   | Examiner  | L              | Sequentially list conditions, b.  |   |                          |  |                            |   |                   |   |                                 |
| 100                                       | ed sit  | ine            | Cause (Disease or injury  | Due to (or as a consequence of):                |                          |  |                            |   |                   |   |                                 |
|   | certificate be executed iding physician and ise as the burial-transit   | Examiner       | that initiated events   | ue to (or as a consec                           | quence of):              |  |                            |   |                   |   |                                 |
| 8760,                                     | siciar<br>buria   | dical E        | d   |   |                          |  |                            |   |                   |   |                                 |
| 9   | ifficate<br>g phys<br>as the  | edi            |   |   |                          |  |                            |   |                   |   |                                 |
| Box                                       | th cert<br>endin  | N/us           | 23b. was decedent pregnant  | es, outcome pf pregn<br>Live birth 2  Fet       | ancy<br>aldeath 3F       | ∃Ectopic pregnancy   | ,                          |   |                   | 23d. Date of deliv  |                                 |
|   | e death   | sicie          | 1 Yes 2 No  | Pregnant at time of                             |                          | Other (specify)  |                            |   |                   | Month   | Day Year                        |
| P.0                                       | at the  | Physician/Med  | 9 LI Unknown  |   | nulting im the Tr        | ndérbina onuco aive  | on in Part I               | 23e Did                                       | tobaccou          | use contribute to   | the cause of death?             |
| S,  | w requires that the death certific<br>been signed by the attending pl<br>should be detached for use as I  | by             | Part II. Other significant conditions contributing  | Ja Ja   |                          | 412  | on mr anti.                |   |                   | □ No 3 □ Pro  |                                 |
| T.  | requ  | eted           |   |   |                          | -  |                            | 24a. Was                                      |                   | ADE W   | topsy findings available        |
| ETHEI                                     | S 55 S  | Completed      |   |   |                          |  |                            | —— auto                                       |                   | prior to co   | ompletion of cause of           |
| E   | <b>uing Physician</b> : The lav<br>I.<br>After this certificate has<br>funeral director, page 2:  |                | 25. Was case referred to medical  |   |                          |  | 26 Place                   | 1  Yes<br>of Death (Check only o              | 2000              | 1 □ Yes   | 2 ∐ No                          |
| VS,                                       | Physician:<br>r this certific<br>ral director,  | To Be          | examiner?   | 1 ☐ Inpatient 2 ☐                               | ER/Outpatier             | nt 3 DOA Oth   |                            | sing Home 5 ☐ Resi                            |                   | 6 □Other (Spec  | ifv)                            |
| BOL                                       | g Phy<br>ter thi  | E              |   | Date of Injury<br>(Month, Day Year)             | 28b. Time o              | f 28c. Injur<br>Worl   |                            | 28d. Describe                                 |                   |   |                                 |
| GIBBONS sion or V                         | Attending r death. ector: After by the fune   | atio           | 1 Natural 5 Pending investigation   |   |                          | M 1 🗆  | Yes 2 □ N                  | 10  |                   |   |                                 |
| GIBBONS, ETHEL Division or Vital Records, | or Att<br>after de<br>Direct<br>in by t   | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e.  | Place of injury - At h<br>building, etc. (Spec. | nome, farm, sti<br>ify)  | eet, factory, office   |                            | 28f. Location (<br>City or To                 |                   |   | ral Route Number,               |
| Ω   | pital ours af   |                | 29a. Certifier 1 Certifying Physician:  | To the best of my kn                            | owledge deat             | h occurred at the tir  | me date an                 | d place, and due to the                       | causals           | and manner as   | stated                          |
|   | 24 hos  | Medical        | (Check only 2 Medical Examiner: Or  |   |                          |  |                            |   |                   |   |                                 |
|   | To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page   | Me             | 29b. Signature and the of certifier   | e-1:  | 20 8                     | 29c. Licens  | e number                   | - 2   | 29d. Da           | ate signed (Month   |                                 |
|   | 1   |                | 1 de le no  | the d   | *                        | 1.   | 150                        | 501   | 2                 | F   | 08                              |
|   | 2 1   |                | 30. Name and address of person who complete   | d cause of death (Ite                           | m 23a) (Type,            | Print)   |                            |   |                   |   |                                 |
| 6   | ).  |                | EDDIE NAKHUDA, M.D.   |   |                          | EY VALLEY  | ROAD                       | TIMON   | IUM               | MD 21   | 093                             |
|   | Sta<br>Regist   |                | 31. Date filed (Month, Day, Year)<br>FEB 1 3 2008   | Registrar's Sign                                |                          | MAN TO THE PARTY OF THE PARTY O |                            |   |                   |   |                                 |
|   | riegisti  | - C            |   | 7   |                          |  |                            |   |                   |   |                                 |

DHMH 17 Rev 1/2001

11:50 P.M.

2008

FEBRUARY 6,

|            |  |                         | Ticasc  |  | ruland / Dan                |   |  |                                    | •                             |                                       |
|------------|--|-------------------------|---|--|-----------------------------|---|--|------------------------------------|-------------------------------|---------------------------------------|
|            |  |                         | For<br>State<br>Registrar   | State of Ma                              | ryland / Dep<br><i>Ce</i>   | ariment of r<br>ertificate of             |  |                                    | 2008                          | 04094                                 |
|            |  | 54                      | 1. Decedent's Name (First, Middle, La.  | st)                                      |                             |   |  | 2. Date of Death                   | Doy Year                      | 3. Time of Death                      |
| E          | Physici  | _                       |   | Paul Sanfo                               | rd Green                    |   |  | Month<br>February                  | 6, 2008                       | 5:45AM M                              |
|            | /Medio   |                         | 4a. Facility Name (If not institution, giv  |  |                             | 4b. City, Town, o                         | r Location of Death                          |                                    | 4c. County of Dear            |                                       |
|            |  |                         | Maplewood Park P  | lace Healtl                              | n Care                      |   | Bethesda                                     |                                    | Mont                          | gomery                                |
|            | Funeral  |                         | 5. Social Security Number 6. S  | ex 7. Age                                | (In yrs. last birthday      |   |  | 8. Date of Birth<br>(Month, Day, Y | 9 Bir                         | thplace (State or Foreign             |
|            | Director   |                         | 577-22-9537   | <b>M</b> M 2□F                           | 90 Yrs.                     | World's Days                              | Hours Will.                                  | June 20,                           |                               | New York                              |
|            | p.   |                         | Usual Residence of Decedent   |  | 10 00 5                     |   |  |                                    |                               | I                                     |
|            | irylar<br>show   | _                       | 10a. State 10b. County  |  | 10c. City, Town or L        | ocation                                   |  |                                    |                               | 10d. Inside City Limits 1 ☐ Yes 2X No |
|            | and sand   | cto                     | Maryland Mont   | gomery                                   |                             |   | Bethesda                                     |                                    |                               |                                       |
|            | 72 hours after death with the Maryland<br>'natural', or items 23a or 28a-f show<br>diral Examiner must be notifiled at   | <b>Funeral Director</b> | 10e. Street and Number  |  |                             | 10f. Zip Code                             |  | 10g                                | . Citizen of What Co          | ountry?                               |
|            | 23a<br>Ust b   | ra                      | 9707 Old Geor   | getown Road                              |                             |   | 20814  |                                    |                               | States                                |
|            | r dea  | ne                      | 11. Marital Status  | 12. Was Decedent E<br>Armed Forces?      | ver in U.S. 13.             | Was Decedent of I<br>If Yes, specify Cub  | Hispanic Origin? (Spo<br>an, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)   | 14. Race - Ame<br>Black, Whit |                                       |
| 98         | or it  | by Fi                   | 1 Never Married 2 Married   | 1 X Yes 2 □ N<br>If Yes, Give            | 0                           | 1 ☐ Yes 2 🛣 No                            | Specify:                                     |                                    | Specify:                      |                                       |
| 21215-0036 | ural"  | d b                     | 3 Widowed 4 Divorced  | Year or Dates:                           |                             |   |  | Lan                                |                               | White                                 |
| 2          | 'nat   | Completed               | 15. Decedent's Ed<br>(Specify only highest gra  | ducation<br>ade completed)               | (Give                       | edent's Usual Occu<br>e kind of work done | pation<br>during most of work<br>ed)         | ing                                | b. Kind of Business           | rindustry                             |
| 12         | within 'ene. than 'e   | 를                       | Elementary/Secondary (0-12)   | College (1-4or 5-                        | -)                          |   |  | 1                                  | Public                        | ations                                |
|            | be filed within 72 hours after death with the Marylan tal Hygiene.  Ind other than "natural", or items 23a or 28a-f show a other than "a went, it work at Examiner must be notified at |                         | 17. Father's Name (First, Middle, Last  |  |                             | Jour                                      | nalist                                       | e (First, Middle, Ma               |                               | actons                                |
| ano        | ntal I   | Be                      |   |  | L1                          |   |  |                                    | ŕ                             |                                       |
| Ž          | 12 should be filed w<br>h and Mental Hygie<br>7 Is marked other t<br>raumatic event, th  | ဥ                       | 19a. Informant's Name/Relationship (  | amin Green                               |                             | ing Address (Street                       | and Number or Run                            |                                    | 1dhandler                     |                                       |
| Maryland   | nd 2 saith an 27 is i  | 18                      | Shirley L. Gree   |  |                             | •   | getown Roa                                   | ,                                  |                               |                                       |
| d)         | E E E  |                         | 20a. Method of Disposition  | II/ WITE                                 |                             | osition (Name of ematory or other pla     |  | Date 20                            | c. Location - City or         | Town, State 20814                     |
| Baltimore, | nt of nt of it it it   |                         | 1 Burial 2 ☐ Cremation 3 ☐  |  | 1                           |   | , rebr                                       | uary                               |                               |                                       |
| ij         | nit. Paratmen<br>ortant:<br>Injury   |                         | 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice   |  |                             | id Cemete                                 | on of Facility Robe                          | art A Pi                           | mphrey Fu                     | ch, Virginia<br>neral Home/           |
| Ba         | permit. Pages 'Department of H<br>Important: If Ite<br>any Injury or of  |                         | 21. Signature of Parietal Service Line  | Y / 1                                    | B. B.                       | thesda-C                                  | hevy Chas                                    | e, Inc. 7                          | 557 Wisco                     | nsin Avenue                           |
|            |  |                         | 220 Port1 Enter the disease, or co-   | p cations that caused                    | MUUJJJ Be                   | etnesda,                                  | Maryland                                     | 20814-330                          | Ţ                             | Approximate                           |
| 1          |  |                         | 23a. Part1. Enter the disease, or conshock, or heart failure. Ist out   | one cause on each line                   | e.                          | nor the mode or dy                        | ing, scorr as oargico                        | or respiratory arres               | .,                            | Interval Between<br>Onset and Death   |
|            | Physician<br>/Medical  |                         | Immediate Cause (Final disease or condition resulting in death)   |  | d Alzheim                   | er's Dise                                 | ase  |                                    |                               |                                       |
|            | Examiner   |                         |   |  | consequence of):            |   |  |                                    |                               |                                       |
| 0.0        |  | -                       | Sequentially list conditions,   | b. Hyperte                               | nsion<br>consequence of):   |   |  |                                    |                               |                                       |
|            | be / * tisc  | Examiner                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | ,  |                             | IT  | <b>1</b>                                     |                                    |                               |                                       |
|            | and and  | хаг                     | that initiated events<br>resulting in death) Last   |  | Prostate   consequence of): | нурегстор                                 | ily  |                                    |                               |                                       |
| 760,       | The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit                      | calE                    |   |  |                             |   |  | ٥                                  |                               |                                       |
| 687        | ficate<br>phys<br>s the  | ğ                       |   | d  |                             |   |  | •                                  |                               |                                       |
| ×          | certifi<br>nding<br>ise a  | Physician/Medi          | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome p                   |                             |   |  |                                    | 23d. Date of de               | liverv                                |
| Вох        | atter<br>I for u   | ciar                    | in the past 12 months?  | 1 □ Live birth :<br>4 □ Pregnant at      |                             | ☐Ectopic pregnand ☐ Other (specify) _     | у  |                                    | Month                         | Day Year                              |
| o.         | that the de<br>led by the a<br>detached to   | ıysi                    | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9□Unknown                                |                             |   |  |                                    |                               |                                       |
| σ.         | res that<br>igned b<br>be deta   |                         | Part il. Other significant conditions   | contributing to death bu                 | t not resulting in the      | underlying cause gi                       | ven in Part I.                               | 23e. Did toba                      | cco use contribute t          | o the cause of death?                 |
| Records,   | uires<br>sigr<br>ld be   | d by                    |   |  |                             |   |  | 1 ☐ Yes                            | 2 □ No 3 □ P                  | robably 4XJUnknown                    |
| 00         | w require<br>been si<br>should b   | Completed               |   |  |                             |   |  | 24a. Was an                        | 24b. Were a                   | utopsy findings available             |
| Re         | he lav<br>ge 2:  | ם                       |   |  |                             |   |  | autopsy<br>performe                | prior to death?               | completion of cause of                |
| a          |  |                         | OF Management to madical  |  |                             |   | 00 51 - 15 -                                 |                                    | No 1 ☐ Yes                    | s 2 □ No                              |
| ₹          | Physician:<br>r this certific<br>ral director,   | Be c                    | 25. Was case referred to medical examiner?  1   Yes 2   No  | Hospital:                                | nt 2 🗆 ER/Outpatie          | ent 3 DOA Ot                              | hor  | h (Check only one)                 | ce 6 □Other (Spe              |                                       |
|            | Phys<br>r this<br>ral dii  | ٠ <u>۲</u>              | 27. Manner of Death   | 28a. Date of Injur                       | y 28b. Time                 | 3[1 3[1 00A]                              | 4 Li Nursing Ho                              | 28d. Describe how                  |                               | эспу)                                 |
| Division   | Attending r death. ector; After by the fune  | tion                    | 1 X Natural 5 ☐ Pending<br>2 ☐ Accident investigatio  | (Month, Day                              | Year) Injury                |   | ork?<br>]Yes 2 □ No                          |                                    |                               |                                       |
| S          | l or Attend<br>after death.<br>Director; /   | fica                    | 3 Suicide 6 Could not b   | e 28e. Place of inju                     | ry - At home, farm, s       | treet, factory, office                    | T  | 28f. Location (Stre                | et and Number or Fl           | ural Route Number,                    |
|            | after<br>Dire  | Certification:          | 4 ☐ Homicide determined   | building, etc                            | . (Specify)                 |   |  | City or Town,                      | State)                        |                                       |
|            | spita<br>ours<br>neral   |                         |   | hysician: To the best o                  |                             |   |  |                                    |                               |                                       |
|            | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral  | Medical                 |   | miner: On the basis of<br>and manner sta | examination and/or i        |   |  |                                    |                               |                                       |
|            | Nithin<br>Vithin<br>Nompi  | Me                      | 29b. Signature and title of certifier   | 160                                      | MA                          | 29c. Licen                                | se number                                    | 290                                | I. Date signed (Mon           | th, Day, Year)                        |
|            |  |                         | > kuli  | votro                                    |                             |   | D20274                                       |                                    | February                      | 6 2008                                |
|            | 1521   |                         | 30. Name and address of person who  | completed cause of de                    | eath (Item 23a) (Type       | , Print)                                  | 220217                                       |                                    | repruary                      | 0, 2000                               |
|            | 13.  |                         | Kirti Vohra, M.D  |  |                             |   | thesda. M                                    | aryland 2                          | .0817                         |                                       |
|            | Sta  | ite                     | 31. Date filed (Month, Day, Year)   |  | r's Signature               | 1 .                                       |  | -                                  |                               |                                       |

DHMH 17 Rev 1/2001

| 08-01107       |  |
|----------------|--|
| Joseph Griffin |  |

|  | 1- For State araend  | #17&18 Per Fte   | thicate of De  | SHOW JH  |   | 2 () (Reg. No.   | 08 0409  |
|--|--|--|--|--|---|--|--|
| Physician/<br>ledical Examine  |  | Last)  | Gr   | iffin  | 2. Date of De<br>Month<br>February  | ath<br>Day Year  | 3. Time of Death<br>1945 hrs   |
|  | 4a. Facility Name (if not institution<br>6810 Park Heights Ave   | give street and number)  | 4b. C  | ity, Town, or Location   |   | 4c. County of Dea  | th   |
| Funeral<br>Director  | 5. Social Security Number  | 5. Sex 7. Age (In yrs. la  | M  | Under 1 Year If Unonths Days Hou   | rs Min.   | Sirth (MM/DD/YYYY) 9. E  | sirthplace (State or eign<br>country) MD   |
| Director   | 219-52-7519 Usual Residence of Decedent  | 1XM 2 F 57   | Yrs.   |  | 04 (  | 0 <b>7</b> 50 0  |  |
| ow any   | 10a. State 10b. County MD NA   |  | Town or Location  ltimore  |  |   |  | 10d. Inside City Limits  1X Yes 2 No   |
| th the Maryland 23a or 28a-f show notified at once.  | 10e. Street and Number   | i - h t - A  | 10f  | . Zip Code <b>21215</b>  |   | 10g. Citizen of What Co  |  |
| with the last 23a or se notifie  |  | 12. Was Decedent Ever in U.  |  | cedent of Hispanic O   | rigin? ( Specify Yes or N   | No- 14. Race - Am  | erican Indian, Black,  |
| ter death with , or items 23.  |  | ried Armed Forces?  1 Yes 2 X No   |  | pecify Cuban, Mexica $2 \mathbf{X}$ No specif  | n, Puerto Rican, etc.)  | White, etc.  | Black  |
| 72 hours aftu<br>n "natural"<br>al Examine<br>leted by   |  | fy only highest grade completed)   | 16a. Decedent's Us   | sual Occupation (Giv<br>f working life, DO NO  | e kind of work done   | 16b. Kind of Busines   | s/Industry   |
| 5-0036 led within 72 l Hygiene. other than " the Medical J   | Elementary/Secondary (0-12)  12th grade  | College (1-4 or 5+) 6yrs   | Registe  | ered Nur   |   | Hospit   | al   |
| 215-0036 be filed within 7 nutal Hygiene. riked other than ent, the Medica   | 17. Father's Name (First, Middle, Charles Griffin  | ast)   |  | 18.Mq[f]   | etherin Co  | Maidin Surname)  |  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martell Hygiers. Important: If titem 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director   | 19a. Informant's Name/Relationsh   | ip (Type, Print )  | 19b. Mailing Add   | ress (Street and No<br>Sunstone  | cir., Pi  | umber, City or Town, Sta<br>kesville,  | ate, Zip Code)<br>Md 21208   |
| ore, N<br>es 1 and 3<br>of Health<br>If item 3   | 20a. Method of Disposition  1 X Burial 2 Cremation   | 3 Removal from State   | Place of Disposition<br>crematory or other p   | lace)  | Date Date   | 20c. Location - City   |  |
| Baltimore, sermit. Pages 1 ar Department of Hee Important: If ite injury or other tr   | 4 Donation 5 Other Special Service L   | ecify: Ar  |  | and Address of Faci  |   | Arbutus  | , Ma   |
|  | XYMULA C   | complicitions that caused the death.   | 1 4 3 0 0  | ch F/H W<br>Mabash<br>ode of dving, such as  | Ave, Bal  | timore, M  | d 21215 Approximate Interval   |
| Physician<br>/Medical<br>caminer   | failure. List only one cause of the mediate Cause (Final disease   | on each line.<br>a. Narcotic intoxic   |  |  |   |  | Between Onset and<br>Death   |
|  | or condition resulting in death)  Sequentially list conditions,  | Due to (or as a consequence of b   | f):  |  |   |  |  |
| ed<br>nsit<br><b>Examiner</b>  | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that militated   | Due to (or as a consequence or   |  |  |   |  |  |
| ecuted and transit   |  | Due to (or as a consequence of d.  | f):  |  |   |  |  |
| 60,<br>e be execul<br>ysician and<br>burial - tra  | X UNPENDED   | AMENDED 27, 28a-f, p   |  | 2/14/08 T <u>T</u>   |   | 23d. Date of deliv   | erv  |
| 6876<br>certificate<br>nding phy<br>se as the l  | IF FEMALE:<br>23b. Was decedent pregnant in the<br>past 12 months?   | I Live birar   | 2 Fetal d  | eath 3 Ecto  | pic pregnancy   | Month  | Day Year   |
| ox 6 ath cer   | No 9 I links   | 4 Pregnant at time of de   | eath 5 Other   | (Specify)  |   | 1  |  |
| O. Box 6876( at the death certificate the death certificate by the attending phy tached for use as the t Physician/M   | <ul> <li>Part II. Other significant condition</li> </ul>   |  | o  |  |   | tobacco use contribute   |  |
| 15, P.O. Box 6 quires that the death cer en signed by the attendit old be detached for use, ted by Physicial   | Part II. Other significant condition   | nown g Unknown   | o  |  |   | es 2 No 3 F  | robably 4 🗹 Unknown  |
| Records, P.O. Box 6  The law requires that the death cer cate has been signed by the attendi page 2 should be detached for use.  | Part II. Other significant condition   | nown g Unknown   | o  | flying cause given in  | 24a. Wa<br>aut<br>pet<br>1 Ye:  | ves 2 No 3 F   | autopsy findings available to completion of cause of   |
| Ital Records, P.O. Box 6 sicins: The law requires that the death cer is certificate has been signed by the attendi director, page 2 should be detached for use; Be Completed by Physicia   | Part II. Other significant conditions  25. Was case referred to medical examiner?  | nown g Unknown   | o  | flying cause given in  | 24a. Wa aul per 1 Yes th (Check only one)   | Yes 2 No 3 F as an 24b. Were prior y formed?   | autopsy findings available to completion of cause of ?  Yes 2 No   |
| n of Vital Records, P.O. Box 6 ding Physician: The law requires that the death cert. After this certificate has been signed by the attendifuneral director, page 2 should be detached for use on: To Be Completed by Physicia  | Part II. Other significant conditions  25. Was case referred to medical examiner?  1 ✓ Yes 2 No  | Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day, Year)  | esulting in the under  | 26.Place of Dea  | th (Check only one)  Nursing Home 5  28d. Describ                                     | ves 2 No 3 P as an 24b. Were prior formed? death s 2 No 1  | autopsy findings available to completion of cause of ?  Yes 2 No   |
| vision of Vital Records, P.O. Box 6 refation of Vital Records, P.O. Box 6 refated.  irretor: After this certificate has been signed by the attention by the funeral director, page 2 should be detached for use, fileation: To Be Completed by Physicial   | Part II. Other significant conditions  25. Was case referred to medical examiner?  1 ✓ Yes 2 No  | Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day, Year)  Find 2/7/2008   | esulting in the under  ER/Outpatient 3  28b. Time of Injury  Fnd 7:30 p  | 26.Place of Dea  DOA Other 28c. Injury at W The state of Dea 28c. Injury at W  | th (Check only one)  Nursing Home 5  ork?  28d. Describ  X No unk  etc. 28f. Location | Yes 2 No 3 F as an 24b. Were prior in death 1 Residence 6 Ot 1   | autopsy findings available to completion of cause of ?  Yes 2 No   |
| Division of Vital Records, P.O. Box 6 sopial or Attending Physician: The law requires that the death cer hours after death.  Including the funeral director, page 2 should be detached for use; the funeral director, nage 2 should be detached for use; Certification: To Be Completed by Physicial   | Part II. Other significant condition  25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death  1 Natural 5 Pendi 2 Accident Invest 3 Suicide 6 X Could determ  | Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day, Year) Fnd 2/7/2008  28e. Place of Injury - At he (Specify) found i   | ER/Outpatient 3  28b. Time of Injury Fnd 7:30 prome, farm, street, farm  | 26.Place of Dea DOA Other 28c. Injury at Wo The Property of the Company of the Co | th (Check only one)  Nursing Home 5  No unk  etc. 28f. Location or Town 6810 Pa       | Residence 6 Other how injury occurred  (Street and Number or , State)  Residence Ave.  | autopsy findings available to completion of cause of ? Yes 2 No her: Scene  Rural Route Number, City Baltimore, MD   |
| Division of Vital Records, P.O. B to Hospital or Attending Physician: The law requires that the d n 24 hours after death. After this certificate has been signed by the temeral Director: After this certificate has been signed by the tenery filled in by the funeral director, page 2 should be detached cal Certification: To Be Completed by Physical Certification: To Be Completed by Physical Physics 1 and 1 an | 25. Was case referred to medical examiner?  1  Yes   | Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day, Year) Find 2/7/2008  28e. Place of Injury - At he (Specify) found inter:On the basis of examination a and manner stated. | ER/Outpatient 3  28b. Time of Injury Fnd 7:30 prome, farm, street, farm residence  | 26.Place of Dea DOA Other; 28c. Injury at Wo The Yes 2 Ctory, office building, at the time, date and in my opinion, death  | 24a. Wa aul per                                   | Residence 6 Other how injury occurred in (Street and Number or , State)  In (Street and Number or , State)  Other how injury occurred in (Street and Number or , State)  Other how injury occurred in (Street and Number or , State)  Other how injury occurred in (Street and Number or , State)  Other how injury occurred in (Street and Number or , State)  Other how injury occurred in (Street and Number or , State)  Other how injury occurred in (Street and Number or , State)  Other how injury occurred in (Street and Number or , State)  Other how injury occurred in (Street and Number or , State) | autopsy findings available o completion of cause of? Yes 2 No  No  her: Scene  Rural Route Number, City  Paltimore, MD  tated. the cause(s)                |
| Division of Vital Records, P.O. Box 6  To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death.  To the Tuneral Director: After this certificate has been signed by the attendiconpletely filled in by the funeral director, page 2 should be detached for use.  Medical Certification: To Be Completed by Physicial  | 25. Was case referred to medical examiner?  1  Yes   | Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day, Year) Find 2/7/2008  28e. Place of Injury - At he (Specify) found inter:On the basis of examination a and manner stated. | ER/Outpatient 3  28b. Time of Injury Fnd 7:30 prome, farm, street, farm residence  | 26.Place of Dea  DOA  Other 28c. Injury at W 1 Yes 2 ctory, office building,   | 24a. Wa aul per                                   | Residence 6 On the how injury occurred  (Street and Number or , State)  Resules(s) and manner as sause(s) and manner as sauses   | autopsy findings available to completion of cause of ? Yes 2 No her: Scene  Rural Route Number, City  Paltimore, MD tated. the cause(s)  Month, Day, Year) |
| 5 5 5 5 C  | 25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1  Natural 5 Pendi Invest  3  Suicide 6  Could detern  29a. Certifier 1 Certifying Phone) 2  Medical Exam  29b. Signature and title of certifier  30. Name and address of person | Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year) Find 2/7/2008 28e. Place of Injury - At hi (Specify) found inter:On the basis of examination a and manner stated.   | ER/Outpatient 3  28b. Time of Injury Fnd 7:30 p ome, farm, street, fa n residence ge, death occurred a ind/or investigation, | 26.Place of Dea DOA Other; 28c. Injury at Wo The Street Corry, office building, at the time, date and in my opinion, death  29c. License numb  | 24a. Wa aud per                                   | Residence 6 On the how injury occurred in (Street and Number or State) ause(s) and manner as stee and place, and due to 29d. Date signed (steed of the how injury occurred in (Street and Number or State) ause(s) and manner as steed and place, and due to 29d. Date signed (steed of the how injury occurred in (Street and Number or State) ause(s) and manner as steed of the how injury occurred in (Street and Number or State) ause(s) and manner as steed of the how injury occurred in (Street and Number or State).   | autopsy findings available to completion of cause of ? Yes 2 No her: Scene  Rural Route Number, City  Paltimore, MD tated. the cause(s)  Month, Day, Year) |

|  |   |                  | For<br>State<br>Registrar  |  | State                            | of Maryl                                      |                                    | ertificate of                           |  | Mental                          | Hygie<br>Reg.               | (- 0                     | 08                    | 04096  |
|--|---|------------------|--|--|----------------------------------|---|------------------------------------|---|--|---------------------------------|-----------------------------|--------------------------|-----------------------|--|
|  | Dharaini  |                  | Decedent's Name (F)  | irst, Middle, Last                     | )                                |   |                                    |   |  |                                 | of Death                    |                          | Voor                  | 3. Time of Death                                   |
|  | Physici<br>/Medic   |                  | Helen  |  |                                  | J.  |                                    |   | dwin                                     |                                 | nary                        |                          | 2008                  | 12:30 PM   |
|  | Examir  | ner              | 4a. Facility Name (If not Keswick N  |  |                                  |   |                                    |   | or Location of De<br>ltimore             | ath                             |                             | 4c. Count                | ty of Death           |  |
| F  | uneral  |                  | 5. Social Security Numb  | per 6. Se                              | х                                | <del></del>                                   | rs. last birthday                  | ) If Under 1 Yea                        | r If Under 24 H                          |                                 | of Birth                    | acl.                     | 9. Birth              | place (State or Foreign ntry)                      |
| D  | irector   |                  | 224-30-47 Usual Residence of Dec   | 23                                     | ]м Ж∏Г                           | 95  | Yrs.                               | Months Day                              | s Hours Mi                               | 02                              | th, Day, Ye                 | 13                       | Con                   | VA   |
| land   | MOI   |                  |  | b. County                              |                                  | 10c.  | City, Town or I                    | ocation                                 |  |                                 |                             |                          |                       | 10d. Inside City Limits                            |
| е Мал  | la-f ah   | ctor             | MD   | NA                                     |                                  |   | Ba.                                | ltimore                                 |  |                                 |                             |                          |                       | 1 X Yes 2 □ No                                     |
| with th  | a or 28   | Dire             | 10e. Street and Number 4312 West   |  | + Day                            | ele Auro                                      |                                    | 10f. Zip Code                           | 21207                                    |                                 | 10g.                        |                          | What Cou              | •  |
| r death  | erns 23   | Funeral Director | 11. Marital Status   |  |                                  | cedent Ever i                                 |                                    | Was Decedent of                         |  | (Specify Yes                    | or No-                      | 14. Ra                   |                       | can Indian,  |
| <b>3-UU30</b> 72 hours after death with the Maryland | "natural", or items 23a or 28a-i show<br>salical Examinat must be notified at   | by               | 1 ☐ Never Married 3 🙀 Widowed 4 ☐  |  | 1 ∐Yes<br>If Yes, G<br>Year or I | 2 <b>M</b> No<br>live<br>Dates:               |                                    | 1 ☐ Yes 2X No                           |  |                                 |                             | Speci                    |                       | Black  |
|  | "natu   | letec            | 15.<br>(Specify o  | Decedent's Edu                         | cation<br>e completed            | )   | (Giv                               | edent's Usual Occi                      | e during most of w                       | vorking                         |                             |                          | Business/In           |  |
| d Z I Z I  | then.   | Completed        | Elementary/Secondar<br>12th grad   |  | College<br>8vrs                  | (1-4or 5+)                                    |                                    | DO NOT use retir                        |  | r                               |                             | olle                     |                       | .ace   |
| d be filed   | other<br>vent,  | Be C             | 17. Father's Name (Firs  |  |                                  |   |                                    |   | 18. Mother's N                           |                                 | liddle, Maid                | den Suma                 | me)                   |  |
| VICE Nould to  | narkec<br>natic s   | To               | Henry Jef  |  |                                  |   |                                    |   | Helen                                    |                                 |                             |                          |                       |  |
| Man and 2 st   | Copparison; of research and welfers registered in popularis. If I tem 27 is marked other than any injury or other traumatic svent, in a Monea.                      |                  | 19a. Informant's Name/ Barbara C   |  |                                  | nter  |                                    | ing Address <i>(Stree</i><br>2 West     |  |                                 |                             |                          |                       | ocode) 21207<br>ore, Md                            |
| es 1 a   | f Item  |                  | 20a. Method of Disposit  | tion                                   |                                  | 20  | b. Place of Disp<br>cemetery, cre  | osition (Name of<br>ematory or other pl |  | Date                            |                             |                          | - City or To          |  |
| Description Pages                                    | tant: I   |                  | 4 Donation 5   | Other (Specify)                        |                                  | State   |                                    | Ridge                                   |  | 6/07                            | P                           | ikes                     | vill                  | Le, Md   |
| Decriii d  | any Ir  | 1                | 21. Signature di Funera  | Service Licens                         | 1 4                              | him   | . M                                | 2. Name and Add<br>arch F/<br>300 Wab   | H West                                   | , Bal                           | timo                        | re,                      | Md                    | 21215  |
|  |   |                  | 23a. Pa /l. Enter the di<br>s ock, or heart fai  | isease, or compl<br>ilure. List only o | ications that<br>ne cause on     | caused the d<br>each line.                    |                                    |   |  |                                 |                             |                          |                       | Approximate<br>Interval Between<br>Onset and Death |
|  | sician<br>ledical   |                  | Imm diate Cause (Fina disease or condition regulting in death)   | al 🔑                                   | . P7                             | al-st   | -                                  | lemente                                 | a  |                                 |                             |                          |                       | Years.   |
|  | aminer  | 1                |  |  | Due to                           | (or as a cons                                 | sequ ince of):                     |   |  |                                 |                             |                          |                       |  |
| P ;  | V ₩   | Iner             | Sequentially list condition if any, leading to immediate. Enter Underlying                             | ons,<br>diate                          | Due to                           | (or as a cons                                 | sequence of):                      |   |  |                                 |                             |                          |                       |  |
| xecute   | and al-trans  | Examiner         | ceuse. Enter Underlyin<br>Cause (Diseese or injur<br>that initiated events<br>resulting in death) Last | ' ]                                    | Due to                           | (or as a cons                                 | seguence of):                      |   |  |                                 |                             |                          |                       |  |
| icate be executed                                    | physicien and sistemate transit   | dical            |  |  | d                                |   |                                    |   |  |                                 |                             |                          |                       |  |
| ortificat  | ing phy<br>as th  |                  | IF FEMALE:   |  |                                  |   |                                    |   |  |                                 |                             |                          |                       |  |
| leath ce   | igned by the attending p<br>be detached for use as  | Physician/M      | 23b. Was decedent pre<br>in the past 12 mon<br>1 \( \text{Yes} \) 2 \( \text{Vol} \) No                | uhs?                                   | 1 Live                           | itcome of pre<br>birth 2 DF<br>nant at time o | etal death 3                       | ☐Ectopic pregnan                        | су                                       |                                 |                             |                          | ate ol delive<br>onth | ery<br>Day Year                                    |
| at the   | by the  | hys              | 9 🗆 Unknown  |  | 9□ Unkr                          |   |                                    |   |  |                                 |                             |                          |                       |  |
| uires th   | n signed<br>Ild be de   | þ                | Part II. Dther significan  | t conditions co                        | ntributing to d                  | death but not                                 | resulting in the                   | underlying cause g                      | iven in Part I.                          | 23e.                            | Did tobacc                  |                          |                       | he cause of death?                                 |
| av ve  | as bee<br>2 shou  | Completed        |  |  |                                  |   |                                    |   |  |                                 | Was an autopsy              | 24b.                     | Were auto             | opsy lindings available impletion of cause of      |
| The T  | page.   | Con              |  |  |                                  |   |                                    |   |  | 101                             | performed                   |                          | death?                |  |
| siclan   | rector  | o Be             | 25. Was case referred to examiner?  1 ☐ Yes 2 ☑ No   |  | lospital:                        | Inpatient 2                                   | ER/Outpatie                        |   | 26. Place of D                           |                                 |                             | . ==                     |                       |  |
| 2 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5              | ter this  | -                | 27. Manner of Death  |  | 28a. Date                        | · · · · · · · · · · · · · · · · · · ·         | 28b. Time                          |   |  | Home 5 28d. Desc                | ribe how in                 |                          |                       | <i>y</i> )   |
| tendin<br>eath.                                      | or: Af  | catic            | 2 Accident   | ☐ Pending investigation ☐ Could not be |                                  |   |                                    | M 1[                                    | ]Yes 2 □No                               |                                 |                             |                          |                       |  |
| al or At   | d in by   | Certification:   | 4 Homicide   | determined                             | 28e. Plac<br>build               | e of Injury - A<br>ling, etc. (Spe            | t home, farm, s<br>ecify)          | treet, factory, office                  | •  | 28I. Local<br>City of           | tion (Street<br>or Town, St | and Num.<br>late)        | ber or Rura           | al Route Number,                                   |
| B Hospit   | To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | Medical (        | 29a. Certifier 1 (Check only one)  | Certifying Phys<br>Medical Exami       | ner: On the t                    | e best of my loasis of exam                   | knowledge, dea<br>ination and/or i | th occurred at the nvestigation, in my  | time, date and plac<br>opinion, death oc | ce, and due to<br>curred at the | the cause                   | e(s) and m<br>and place, | anner as s            | tated.<br>the cause(s)                             |
| To the   | То th   | Me               | 29b. Signature and title   | 1                                      | ^                                |   |                                    |   | se number                                |                                 | 29d.                        | Date signe               | ed (Month,            | Day, Year)   |
|  |   |                  |  | helle 170                              | V                                | rego  |                                    |   | 3657                                     |                                 | Tel                         | bruar                    | y 11,                 | 2008   |
|  | 3   |                  | 30. Name and address of TSABETUE   | = Mre                                  | REGO                             | R, 71   | 28 W. 48                           | THE STRE                                | ET, BAL                                  | 57070R                          | E, r                        | かえ                       | 1211                  |  |
|  | Sta<br>Registr  |                  | 31. Date liled (Month, D   | ay. Year)                              | 8                                | Registrar's Sig                               | gnature                            | mes)                                    |  |                                 |                             |                          |                       |  |

| Division or Vital Records, P.O. Box 68760,   | 1    | Baltimore, Mar             |
|--|------|----------------------------|
| the Hospital or Attending Physician: The law requires that the death certificate be executed U     | Ph   | permit. Pages 1 and 2 sl   |
| ē  | V    | Department of Health an    |
| the Funeral Director: After this certificate has been signed by the attending physician and        | sic  | Important: If Item 27 is r |
| pletely filled in by the funeral director, page 2 should be detached for use as the burial-transit | ei a | any injury or other traur  |
|  |      |                            |

| The street and Number   Cardiomyopathy   Congestive   Cardiomyopathy   Congestive   Cardiomyopathy   Cardi   |                                      | 1 - State of Maryland / Depart  | noute of Boutif  | neg. M                                       | 0.   | 0409               |
|--|--------------------------------------|--|--|--|--|--------------------|
| Former of Direction of Department of Control Process of Section of Department of Direction of Department of Depart |                                      |  |  | Month Da                                     | ay Year  |                    |
| Director    Third   Director   Di |                                      |  |  |  | -  | .20 a              |
| The state of the s |                                      | 2317 01d Joppa Road  | Joppa  |  | Harford  |                    |
| The control of the    | Funeral                              | 1 F44 2 F F  |  | B. Date of Birth<br>(Month, Day, Year        | 9. Birthplace<br>Country)                          | (State or Foreig   |
| The Court of the Part of the Court of the Court of the Court of the Part   | Director                             | 212-00-300)  |  | 11/28/1951                                   | l Maryla   | ınd                |
| 17   Father's Name (First, Micsie, Last)   18   Mostler's Name (First, Micsie, Masses Surrame)   18   Mostler's Name (First, Micsie, Masses Surrame (First, Micsie, Masses Surra   | /land                                |  | tion   |  | 10d.   | Inside City Limits |
| 17   Father's Name (First, Micsie, Last)   18   Mostler's Name (First, Micsie, Masses Surrame)   18   Mostler's Name (First, Micsie, Masses Surrame (First, Micsie, Masses Surra   | a-f sh<br>iffled s                   | MD Harford Joppa   |  |  |  | 1 □Yes 2▼No        |
| 17   Father's Name (First, Micsie, Last)   18   Mostler's Name (First, Micsie, Masses Surrame)   18   Mostler's Name (First, Micsie, Masses Surrame (First, Micsie, Masses Surra   | or 28<br>e not                       | 10e. Street and Number   |  | 10g. C                                       | itizen of What Country?                            |                    |
| 17   Father's Name (First, Micsie, Last)   18   Mostler's Name (First, Micsie, Masses Surrame)   18   Mostler's Name (First, Micsie, Masses Surrame (First, Micsie, Masses Surra   | ath w s 23a nust t                   | 2317 Old Joppa Road  |  |  |  |                    |
| 17   Father's Name (First, Micsie, Last)   18   Mostler's Name (First, Micsie, Masses Surrame)   18   Mostler's Name (First, Micsie, Masses Surrame (First, Micsie, Masses Surra   | items<br>iner in                     | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 \( \text{I Never Married} \) 2 \( \text{Married} \) 1 \( \text{Ves} \) \( \text{Y} \) No  | s Decedent of Hispanic Origin? (Spec<br>es, specify Cuban, Mexican, Puerto R   | ify Yes or No-<br>ican, etc.)                |  | ndian,             |
| 17   Father's Name (First, Micsie, Last)   18   Mostler's Name (First, Micsie, Masses Surrame)   18   Mostler's Name (First, Micsie, Masses Surrame (First, Micsie, Masses Surra   | urs af                               | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:   | Yes 2 No Specify:  |  | Specify: B1  | ack                |
| 17   Father's Name (First, Micsie, Last)   18   Mostler's Name (First, Micsie, Masses Surrame)   18   Mostler's Name (First, Micsie, Masses Surrame (First, Micsie, Masses Surra   | 72 hor 72 hor ratural lical E        | 15. Decedent's Education 16a. Deceden (Specify only highest grade completed) (Give kin   | nt's Usual Occupation  | 16b. I                                       | Kind of Business/Indust                            | ry                 |
| 17   Father's Name (First, Micsie, Last)   18   Mostler's Name (First, Micsie, Masses Surrame)   18   Mostler's Name (First, Micsie, Masses Surrame (First, Micsie, Masses Surra   | ithin ithin an "nan "nan "nan mple   | Elementary/Secondary (0-12) College (1-4or 5+)   | _  |  |  |                    |
| 20. Method of Disposition   20. Continue   20. Co   | Liber th                             | 12 yrs. 3 yrs Fig. 17 Eather's Name (First Middle Last)  |  |  | 0  |                    |
| 20. Method of Disposition   20. Continue   20. Co   | d be f<br>antal h<br>ed of<br>ed of  |  | `  |  | •,   |                    |
| 20. Method of Disposition   20. Continue   20. Co   | should Me mark marking TC            |  |  |  | - J  | de)                |
| Carried Community of Communit   |                                      |  |  |  |  | •                  |
| Physician (Medical Examiner)  23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate informatiac clause (Final Immediate Cause) (Final Immediate) (Final Immed | of Hear                              | 20a. Method of Disposition 20b. Place of Disposition   |  |  |  | State              |
| Physician (Medical Examiner)  23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate informatiac clause (Final Immediate Cause) (Final Immediate) (Final Immed | Page<br>nent of                      | I La Durial 2 Licremation 3 Linemoval from State 1   | The state of the s | 2/2008 Ba                                    | altimore,MD  | )                  |
| Physician Medical Examiner    Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician Medical Examiner   Physician   Physician Medical Examiner   P | permit. Departr Importa any inju     | h n i  |  |  |  | -                  |
| Physician (Modical Examiner)  The property of  | (USHA                                | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter t  |  |  |  |                    |
| Due to (or as a consequence of):   | Physician                            | Immediate Cause (Final   | Concentive   |  | On   | iset and Death     |
| Due to [or as a consequence off:    Due to [or as a consequence off:   Due to [or as a | /Medical                             |  | , congestive   |  |  | <u> rears</u>      |
| The part of the pa | AN                                   | Sequentially list conditions D.  |  |  |  |                    |
| FFEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome pf pregnancy   23d. Date of delivery   23d   |                                      | Due to for as a consequence of:  |  |  |  |                    |
| FFEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome pf pregnancy   23d. Date of delivery   23d   | xecul<br>and<br>al-tran              | that initiated events resulting in death) Last C   | -  |  |  |                    |
| FFEMALE: 23b. Was decedent pregnant   1   1   1   1   1   1   1   1   1  | e be e siciar siciar e buril         |  |  |  |  |                    |
| FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Wes 2   No 3   Probably 4   Unknown   1   Wes 2   No 3   Probably 4   Unknown   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?   1   Wes 2   No 3   Probably 4   Unknown   25b. Were autopsy performed?     |                                      |  |  |  |  |                    |
| 1   Yes 2   No 3   Probably 4   Unknown   Part II.   23e. Did tobacco use contribute to the cause of death?   1   Yes 2   No 3   Probably 4   Unknown   1    | ath cer<br>attendin<br>for use       | IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome pf pregnancy   1 □ I ive birth   2 □ Fetal death   3 □ F    | ctopic pregnancy   |  |  |                    |
| Hypertension, Renal Failure, Type II Diabetes  1   Yes   2x   No   3   Probably   4   Unknown    24a. Was an   24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24a. Was an   24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to co | - 0 o o                              | in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown  |  |  | Month Day  | y Year             |
| Hypertension, Renal Failure, Type II Diabetes  1   Yes   2x   No   3   Probably   4   Unknown    24a. Was an   24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24a. Was an   24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to completion of cause of death?  1   Yes   2x   No   3   Probably   4   Unknown    24b. Were autopsy findings availat prior to co | d by th                              | Part II Other eignificant conditions contributing to doubt but not reculting in the under  | arlying cause given in Port I  | 220 Did tohacco                              | uno contributo to the c                            | auso of doath?     |
| 243. Was an autopsy performed? 1   Yes 2   No    246. Place of Death (Check only one)  25. Was case referred to medical examiner? 1   I   I   I   I   I   I   I   I   I  |                                      |  | · -  |  |  |                    |
| The property of the property o | v requ<br>been<br>shoulk             | Topic of the state | Addictor   |  | A  |                    |
| The property of the property o | he lav<br>e has<br>ge 2 ;            |  |  | autopsy                                      | prior to comple<br>death?                          |                    |
| The property of the property o | in: T<br>ifficate<br>or, pa          |  | 26. Place of Death   |  | o 1 □Yes 🏋   | ] No               |
| The property of the property o | ysicir<br>is cer<br>direct           | examiner?  | Othor  |  | 6 □Other (Specify)                                 |                    |
| 28f. Location (Street and Number or Rural Route Number, State)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier and manner stated.  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)   | ig Ph<br>ter th<br>neral             | 27. Manner of Death 28a. Date of Injury 28b. Time of (Month, Day Year) Injury  |  |  |  |                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   | endir<br>sath.<br>or: Al<br>he fu    | 2 Accident investigation   |  |  |  |                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   | or Att<br>ter de<br>lirect<br>n by t | 3 Suicide 4 Homicide determined 28e. Place of injury - At home, farm, street building, etc. (Specify)  | t, factory, office 28  | Bf. Location (Street a<br>City or Town, Star | and Number or Rural Ro<br>te)                      | oute Number,       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   | pital curs af                        | COn Cortification   1 M Contificion Physicians To the heat of my impulsation double of   | coursed at the time date and place a   |  | ->   |                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   | Hos<br>24 ho<br>E Fun<br>etely i     | (Check only one)    Check only one   Che | stigation, in my opinion, death occurre  | d at the time, date a                        | o, and manner as state<br>nd place, and due to the | cause(s)           |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   | o the comple                         | 29b. Signature and title of certifier  | 29c. License number  | 29d. Di                                      | ate signed (Month, Day                             | , Year)            |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   | F > F 0                              | > John & Mana  | D25075   | 20   | 6 04 2   | 008                |
| John F. Marra, M.D., 5601 Loch Raven Blvd., Baltimore, MD 21239  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature   |                                      | 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin   | nt)  |  | _  |                    |
| State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |                                      | John F. Marra, M.D., 5601 Loch Ra  | ven Blvd.,Baltimo  | re, MD 21                                    | 239  |                    |
|  |                                      | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | ,  |  |  |                    |

| 08-01131       |  |
|----------------|--|
| Vernon Hibline |  |

| 8-01131<br>/ernon Hibline   |                | Please Type or Print in Black Indelible Ink. Ensure All Copic State of Maryland / Department of Health and Mental H  | <mark>es Are Legi</mark><br>lygiene        | ble.<br>200                                       | 8 0409   |
|---|----------------|--|--|---|--|
|   | B              | For State Certificate of Death   | Reg  | . No.   | 3. Time of Dooth                                   |
| Physician<br>Medical Examine  | er             | 1. Decedent's Name (First, Middle,Last)  Vernon T. Hibline Sr.   | February 8,                                |   | 3. Time of Death<br>1810 hrs                       |
|   | •              | 4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Rosedale   |  | 4c. County of Death<br>Baltimore Cou              |  |
| Funeral<br>Director   |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr 20 - 34 - 6782 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr Months Days Hours Min  | _  | (MM/DD/YYYY) 9. Birt<br>Foreig<br>7,1938 Cou      | n  |
| and<br>show any<br>nce.   |                | Usual Residence of Decedent  |  |   | 10d. Inside City Limits  1 Yes 2 XNo               |
| death with the Maryland or items 23a or 28a-f sho   | ă<br>L         | 10e. Street and Number 824 Dorsey Road 21221   | 109  | g. Citizen of What Cour<br>USA                    | ntry?  |
| 55 n.L  | Fune           | 11. Marital Status  1 Never Married 2 Married Never Married 2 Married Never Married 3 Wildowed 4 X Divorced If Yes, Give Year 1 Yes 2 No specify:  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Substituting If Yes, specify Cuban, Mexican, Puerton If Yes, Specify:  14. Was Decedent Ever in U.S.  15. Was Decedent of Hispanic Origin? (Substituting If Yes, Specify Cuban, Mexican, Puerton If Yes, Specify: If Ye | Specify Yes or No-<br>o Rican, etc.)       | White, etc.                                       | ite  |
| 36<br>in 72 hours at<br>han "natural<br>dical Examin  | Completed by   | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  1 2 th  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use report of the policeman Policeman   |  | 16b.Kind of Business/I<br>Baltimor<br>Police D    | •  |
| d with  | 틹              |  | ne (First, Middle, M                       |   |  |
| 21215-0036 Juld be filed within 7 Mental Hygiene marked other than ie event, the Medica   | <u></u>        | Charles Hibline Agnes  |  |   | <u>.</u>   |
| MD 21 ad 2 should 1 th and Mer m 27 is man aumatic ev   |                | 19a. Informant's Name/Relationship (Type, Print)  Vernon Hibline Jr./ son  19b. Mailing Address (Street and Number or 90 Southeast Tal   | no Terra                                   | ace Stuar   | t FL   |
| re, r<br>  and<br>  Healt<br>  Fitem<br>  er trau   | 1              | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  Removal from State   |  | 20c. Location - City or                           |  |
| Baltimore,<br>permit. Pages I at<br>Department of He<br>Important: If ite   | -              | 4 Donation 5 Other Specify:  |  | Baltimo<br>Ave. Ba                                |  |
| Ba<br>Perm<br>Depr<br>Imp   |                | Connelly Funer   | cal Home                                   | e of Esse   | x 21221  |
| Physician<br>/Medical   |                | 23a. Part I. Enter the diseas, or complications that causal the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive atherosclerotic cardiovascular descriptions)   |  | st, shock, or heart                               | Approximate Interval<br>Between Onset and<br>Death |
| xaminer   |                | or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.  |  |   |  |
|   | Examiner       | If any, leading to himiculate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |  |
| executed<br>an and<br>al - transi   | ᇹ              | d.  X UNPENDED  X AMENDED 27 POWME 9876 2/20/08 TT   | · · · · · · · · · · · · · · · · · · ·      |   |  |
| 68760, ertificate be ding physici e as the buri   |                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  | nancy                                      | 23d. Date of deliver<br>Month                     | y<br>Day Year                                      |
| Box<br>death of<br>the atten  | ysic           | 4 Pregnant at time of death 5 Other (Specify) 9 Unknown  |  |   |  |
| P.O.   es that the igned by the coe detache   | 2              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | bacco use contribute to                           |  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit | Completed      |  | 24a. Was a autope perfor                   | sy prior to<br>med? death?                        | utopsy findings available completion of cause of   |
| tal F   | 8              | 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other; 1 Nur.   |  | Duridana o Doub                                   |  |
| sion of Vital Attending Physician: rdeath. ector: After this certif   | 의              | 1 ✓ Yes 2 No Inpatient 2 ✓ ER/Outpatient 3 DOA 4 Number of Death  27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  |  | Residence 6 Othe                                  | er:  |
| ivision or Attend after death. Director:  | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.   | 28f. Location (S<br>or Town, S             |   | ural Route Number, City                            |
| Division  Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the  |                | 4 Homicide (Specify)  29a. Certifier (Check only one)  29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.  | and due to the caus<br>d at the time, date | e(s) and manner as sta<br>and place, and due to t | ted.<br>he cause(s)                                |
| To t<br>To tl   | Medical        | 29b. Signature and title of certifier 29c. License number  |  | 29d. Date signed (M                               |  |
|   |                | O.C.M.E.   |  | February 9, 200                                   | 8  |
| OCME  |                | 30. Name and address of person who completed cause of death (Item 23a)  Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore,   | MD 21201                                   |   |  |
| Sta<br>Registr  |                | 31. Date filed (Month, Day, Year)  FFB 1 3 2008  32. Tegistrar's Signature   |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 10:34AM M Dorothy Mae Henry 2008 February 11, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery <u>Suburban Hospital</u> Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🛣 F Months Yrs. 82 Director February 6, 1926 579-42-5876 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show a or 28a-f show be notified at 1 ☐ Yes 2 No Director Virginia Fairfax Fairfax 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number "natural", or items 23a 22030 Funeral 12724 Olivia Drive United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: ۾ 3 X Widowed 4 □ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Election Supervisor County Government 12 should be filed w h and Mental Hygie 7 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel K. O'Connor Mary Cecilia Hill ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trai Richard Vincent Henry/ Son <u>12724 Olivia Drive, Fairfax, Virginia 22030</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State February 15, 2008 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M00335 23a. Part1. Enter the insease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): **Examiner** PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): EMPHYSEMA Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗹 No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ 100 24a. Was an autopsy performed? Yes 2 ☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t 1 Matural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

7

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Records,

Vital

Division or

State Registrar Truong Bao, M.D. 9715 Medical Center Drive, Rockville, Maryland 20850 32. Registrar's Sighature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

DO057124

29d. Date signed (Month, Day, Year) 2/12/08

08-00962

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 04100

| Robert Louis Jae   | ~              | - For State                          | S   | tate of M                      | faryland /                       |                 |                  | of Health<br>of Death        |                               | nental Hyg                           |                               |                                | 20                           | 0910  |
|--|----------------|--------------------------------------|---|--------------------------------|----------------------------------|-----------------|------------------|------------------------------|-------------------------------|--------------------------------------|-------------------------------|--------------------------------|------------------------------|---|
|  |                | Registrar<br>1. Decedent's Nan       | no (Eiret Mide                                    | tle Last)                      |                                  | — Ceri          | incate C         | Death.                       |                               | 2                                    | Date of Dea                   | eg. No.<br>th                  |                              | 3. Time of Death                            |
| Physicia<br>M∽‴∼al Examir  |                |                                      | ert Lou   |                                | Jaeger                           |                 |                  |                              |                               |                                      | Month<br>February             | Day<br>3, 2008                 | Year                         | 1110 hrs                                    |
| W di Zadiiii   |                | 4a. Facility Name                    |   |                                |                                  |                 |                  | 4b. City, To                 | own, or Loca                  | ation of Death                       |                               | 4c. Cou                        | nty of Death                 | n   |
|  |                | 118 Linest                           | one Road  |                                |                                  |                 |                  | Hanco                        | ock                           |                                      |                               |                                | nington                      |   |
| Funeral  |                | 5. Social Security                   | Number  | 6. Sex                         | 7. Ag                            | e (In yrs. la   | st birthday)     |                              |                               | f Under 24Hrs.                       | 8. Date of Bi                 | rth(MM/DD/Y                    | YYY) 9. Bir<br>Forei         | rthplace (State or                          |
| Director   | l              | 212-54-0                             | 0334  | 1XXM                           | 2 F                              | 57              | Y                | rs. Months                   | s Days                        | Hours Min.                           | 04/24                         | /1950                          | Cc                           | ountry) New York                            |
|  | H              | Jsual Residence of Decedent          |   |                                |                                  |                 |                  |                              |                               |                                      |                               |                                |                              |   |
| any  | ı              | 10a. State                           | Da. State 10b. County 10c. City, Town or Location |                                |                                  |                 |                  |                              |                               |                                      |                               | 10d. Inside City Limits        |                              |   |
| nd<br>Show   | ٦              | MD                                   | Wash  | ningto                         | n                                |                 |                  | Har                          | ncock                         |                                      |                               |                                | 1 X Yes 2 No                 |   |
| laryla   | Director       | 10e. Street and N                    |   |                                |                                  |                 |                  | 10f. Zip                     |                               |                                      |                               | 10g. Citizen o                 |                              |   |
| the N  |                | 118 Li                               | nestone   | e Rd.                          |                                  |                 |                  |                              | 2175                          |                                      |                               |                                |                              | States                                      |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Funeral        | 11. Marital Status                   |   |                                | Was Decedent<br>Armed Forces     |                 | S. 13. V         | Vas Decede<br>f Yes, specif  | ent of Hispan<br>fy Cuban, Me | nic Origin? (Spe<br>exican, Puerto F | cify Yes or N<br>Rican, etc.) |                                | Race - Ame<br>White, etc.    | rican Indian, Black,                        |
| death<br>or ite  | Ē              | 1 Never Mar                          |   | viairieu 1                     | X Yes 2                          | No              |                  |                              |                               |                                      |                               | Spec                           | cific V                      | Vhite                                       |
| after  | by             | 3 Widowed                            |   |                                | s, Give Year 19<br>ates:         |                 |                  | Yes 2                        |                               | (Give kind of wo                     | ork done                      |                                | of Business                  |   |
| hours  |                | 15. Decedent's                       |   |                                | college (1-4 or                  |                 | during           | most of wor                  | rking life. DC                | NOT use retire                       | ed)                           |                                |                              |   |
| 36<br>in 72<br>han "   | plet           | Elementary/Se 12                     | condary (0-12                                     | :)                             | Sollege (1-4-01                  | 5.,             |                  | Plumbe                       | er                            |                                      |                               | I                              | Plumbi                       | ing   |
| OO;<br>with<br>grene<br>her t  | Completed      | 17. Father's Nam                     | e (First, Middl                                   | e. Last)                       |                                  |                 |                  |                              | 18.1                          | Mother's Name                        | First, Middle,                | Maiden Surr                    | name)                        |   |
| 15.  | BeC            |                                      | uis   | Arth                           | ur                               | Jaege           | er               |                              |                               | Betty                                |                               |                                | ndquis                       |   |
| 212<br>212<br>Ment Ment mark   | lo E           | 19a. Informant's I                   |   |                                |                                  |                 | 19b. Mai         |                              |                               | nd Number or R                       |                               |                                |                              |   |
| MD 2 sho h and 27 is smarti  |                | Christ                               | ine Ber   | nedict                         | / Daug                           | hter            |                  |                              |                               | Dr., Fr                              |                               |                                |                              |   |
| e, lend I and Healt Healt item   |                | 20a. Method of D                     | isposition  |                                | Removal from S                   | 20b.            | Place of Disport | oosition (Nar<br>other place | me of cemet<br>e)             |                                      | Date                          |                                | ·                            | or Town, State                              |
| nor<br>Pages<br>ent of<br>nt: 11   |                |                                      | 5 Other   |                                | temoval from 3                   | idic            |                  | ke Cre                       |                               | cy 2/8                               | 3/08                          | Be 3                           | ltsvi]                       | lle, MD                                     |
| altir<br>mit. F<br>vartme<br>portal  | 1              | 21. Sig etur                         | Funeral Service                                   | ce Lidensee                    |                                  | no038.          | 2 2              | Name and                     | Address of                    | Facility<br>aI and C                 | remati                        | ion Sei                        | rvices                       | 3   |
| ii ii g g  | 0 1            | Stu                                  | lu An   | dun                            | 11.111                           |                 | T                | 933 G-                       | ist Av                        | ze. Silv                             | er Spi                        | ring. N                        | MD 2                         | 20910                                       |
| Physician  |                | 23a. Part I. Engli                   | the disease,                                      | or complicati<br>se on each li | ons that cause                   | d the death     | . Do not ente    | er the mode                  | of dying, su                  | ch as cardiac or                     | respiratory a                 | rrest, shock,                  | or neart                     | Approximate Interval<br>Between Onset and   |
| Medical xaminer  |                | Immediate Caus                       | e (Final disea                                    | se a.Per                       | itonitis                         |                 |                  |                              |                               |                                      |                               |                                |                              | Death                                       |
| Zaimiei  |                | or condition resu                    | ilting in death)                                  |                                | to (or as a cons                 |                 |                  |                              |                               |                                      |                               |                                |                              |   |
|  | -              | Sequentially list if any, leading to | conditions,                                       |                                | forated Gas                      |                 |                  |                              |                               |                                      |                               |                                |                              |   |
|  | Examine        | cause. Enter Ur                      | derlying Caus                                     | se c.                          | ·                                |                 |                  |                              |                               |                                      |                               | <u>-</u>                       |                              |   |
| _ =  | xan            | events resulting                     |   |                                | to (or as a con                  | sequence o      | of):             |                              |                               |                                      |                               |                                |                              |   |
| ecuter<br>and<br>trans   | alE            |                                      |   | d                              |                                  |                 |                  |                              |                               |                                      |                               |                                |                              |   |
| (0,<br>e be executed<br>ysician and<br>burial - transit  | edical         | UNPEND                               | ED  |                                | MENDED                           |                 |                  |                              |                               |                                      |                               | 234 D                          | ate of deliv                 | env   |
| 30x 6876(<br>death certificate<br>e attending phys   | N/M            | IF FEMALE:<br>23b. Was decede        | ent pregnant in                                   |                                | 3c. If yes, outco                | ome of pre      | gnancy<br>2      | Fetal death                  | 3                             | Ectopic pregna                       | incy                          |                                | onth                         | Day Year                                    |
| r 68<br>certif   | ia             | past 12 mon                          | ths?  | 4                              | L                                | at time of d    |                  | Other (Spe                   |                               |                                      |                               |                                |                              |   |
| Box<br>e death<br>the atte   | Physician/M    |                                      |   | Jnknown g                      | -                                |                 |                  |                              |                               |                                      |                               |                                | 125.12                       | to the course of donth?                     |
| O.  <br>at the<br>d by t   |                | Part II. Other si                    | gnificant con                                     | ditions cor                    | ntributing to dea                | ath but not     | resulting in t   | he underlyin                 | ng cause giv                  | en in Part I.                        |                               |                                |                              | to the cause of death?  Probably 4  Unknown |
| b, P.O. ires that the signed by 1 be detached  | d b            | Cirrhosis                            | of liver  |                                |                                  |                 |                  |                              |                               |                                      |                               |                                |                              | autopsy findings available                  |
| rds<br>requi<br>been<br>hould  | Completed      |                                      |   |                                |                                  |                 |                  |                              |                               |                                      |                               | topsy                          | prior t                      | to completion of cause of                   |
| e law<br>te has  | Ĕ              | ·                                    |   |                                |                                  |                 |                  |                              |                               |                                      |                               | rformed?<br>s 2 No             | death<br>1                   |   |
| ERGINETH The Tifficat  | ပို            | 25. Was case re                      | eferred to med                                    | lical                          |                                  |                 |                  |                              | 26.Place o                    | of Death (Check                      | only one)                     |                                |                              |   |
| of Vital Records, ing Physician: The law requir After this certificate has been suneral director, page 2 should  | B B            | examiner?                            | 2 No  | Hosp                           | oital: 1 Inpa                    | tient 2         | ER/Outpa         | tient 3                      | DOA O                         | ther 4 Nursir                        | ng Home 5                     |                                | e 6 🗸 Ot                     | ther: Scene                                 |
| n of V<br>ling Phy<br>After th   | 2              | 27 Manner of D                       |   |                                | 28a. Date of In<br>(Month, Day   | njury<br>(Year) | 28b. Time        | of Injury                    | 28c. Injury                   |                                      | 28d. Descri                   | be how injury                  | occurred                     |   |
| On<br>endiin<br>ath.<br>or: A  | 🚊              | 1 V Natural                          |   | ending<br>rvestigation         |                                  |                 |                  |                              |                               | es 2 No                              |                               |                                |                              |   |
| /isi<br>nr Att<br>ter de<br>ter de<br>irrecti  | ES             | 2 Acciden 3 Suicide                  |   | could not be                   | 28e. Place of                    | Injury - At     | home, farm,      | street, factor               | ry, office bui                | ilding, etc.                         |                               | n (Street and<br>n, State)     | Number or                    | Rural Route Number, City                    |
| Division Septial or Attend hours after death. meral Director:  | Certification: | 4 Homicio                            | le  | etermined                      | (Specify)                        |                 |                  |                              |                               |                                      |                               |                                |                              |   |
| 11 4 7 1 E   |                |                                      | Certifying  | g Physician:                   | To the best of                   | my knowle       | edge, death o    | occurred at the              | he time, date                 | e and place, and<br>death occurred   | d due to the c                | ause(s) and t<br>ate and place | nanner as s<br>e, and due to | stated.<br>o the cause(s)                   |
| To the within To the comple  | Medical        | one) 2                               |   | an                             | the basis of e<br>d manner state | d.              | and/or inves     |                              |                               |                                      |                               |                                |                              | 'Month, Day, Year)                          |
|  | Ž              | 29b. Signature                       | and title of cer                                  | rtifier                        | · · · ·                          |                 |                  | 2                            | 9c. License<br>O.C.N          |                                      |                               | 1                              | uary 4, 20                   |   |
| 1  |                |                                      | ard   | 2 4                            | all                              | an              |                  |                              | U.U.IV                        | 1.⊆.                                 |                               | 1 6010                         | ¬, 21                        |   |
| 1  |                | 30. Name and a                       |   |                                |                                  |                 | em 23a)          | nn Ctroct                    | Raltima                       | re, MD 2120                          | 11                            |                                |                              |   |
| 1011   |                | Carol Alla                           |   |                                | Medical Ex                       |                 |                  | ını Sueet                    | ., Dailillio                  | , IVID 2 120                         |                               |                                |                              |   |
|  | State          |                                      | nonth, Day, Ye                                    | ear)                           |                                  | trar's Signa    | K A              | 1346                         |                               |                                      |                               |                                |                              |   |
| Regis  | ગાઇ            | 4                                    | FAI   | ₹ <000                         | 100000                           | Med A           | 200              |                              |                               |                                      |                               |                                |                              |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00832 State of Maryland / Department of Health and Mental Hygiene Stephen L Joyner 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day January 30, 2008 **Medical Examiner** c County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number Montgomery Poolesville 17666 Kohlhoss Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Days Months Hours Director Country) ILL 319-46-4878 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No 28a-f show , or items 23a or 28a-f show must be notified at once. Director 10a, Citizen of What Country 10f. Zip Code 10e. Street and Numbe U.S.A. 7666 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 X Never Married Yes Specify: WHITE Yes 2 No specify: If Yes. Give Year Widowed Divorced other traumatic event, the Medical Examiner item 27 is marked other than "natural", à Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) mit. Pages 1 and 2 should be filed within 72 l partment of Health and Mental Hygiene. portant: If item 27 is marked other than "r MD 21215-0036 Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KOHIHOSS Rd-Podesuscie, Md. 20837 KENNETh 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 2 Cremation 3 HANOVER. Donation 5 Other Specify: 21. Signature of Funeral Service Licenses EdMONDSON AVE -23a. Part Lever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. (Martina) Death a. Atherosclerotic cardiovascular disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Gause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical #23a,PII,27,perME,g87 perME, g876, 2/13/08 XUNPENDED ned by the attending physician detached for use as the burial -Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. P.O. Part II. Other significant conditions þ Yes 2 No 3 Probably 4 V Unknown Chronic alcohol abuse Completed Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? 1 🗸 page Yes 2 certificate 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician; Be examiner? Residence 6 V Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 3 this 1 ✔ Yes ٩ 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of tnjury 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending within 24 hours after death. Funeral Director: stely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

To with the court

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D.

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

State Registrar ·1/31/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 | | | | | | | | | | | | 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day TEBRURARY NAVARRO 2008 JOHNSON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BON SECOURS HOSPITAL N/A BALTIMORE 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Sex 1¥EXM 2□F **Funeral** Hours Director 214-38-5546 68 MARYLAND JUL. 29 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 XYes 2 No must be notified Director MARYLAND BALTIMORE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ō 19 S. CALHOUN ST. U.S.A.

14. Race - American Indian, APT 2F 21213 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ Yes If Yes, Give Year or Dates: 1XX Never Married 2 ☐ Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes Ž**OX**No Specify Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) llth grade CATHOLIC CHARITIES FLOOR TECH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F JOSEPH JOHNSON SR. EMILY JOHNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 3722 E. Lombard St., Baltimore, Maryland 21224 Paula M. Johnson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
any injury or ot 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT ZION CEMETERY 02-18-08 LANSDOWNE, MARYLAND 21. Signature of Funetal Service Licenses 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Darbasa 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -ARYNGEAL **Physician** TEN / EARS disease or condition resulting in death) /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. E. ite. Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a. Was an autopsy 1∐ Ýes 2**⊠**No 2 100 1 205×40 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending investigation Injury To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide X CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of cettifier 29d. Date signed (Month, Day, Year) 10061765 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) FEB 13

FRENEZEIL QUAINOU M 3350 WILKENS AVE #507 BACTIMONE MO 21225 32. Registrar's Signature 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician loh nson 2008 February /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Asnes MD Hospita | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | Month, Day, | Month | 5. Social Security Number . Age (In yrs. last birthday) **Funeral** 220-74-53 Usual Residence of Decedent 1 MM 2□F Months MARY Director 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 √Yes 2 No Director MORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Eyer in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marita Status Black, White, etc. 1 Never Married 2 Married Specify: Black 21 No Baltimore, Maryland 21215-0036 'natural", or þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education Give kind of work done during most of working life. DO NOT use retired (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 0 hnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City Town. State. Zip Code. permit. Pages 1 and 2:
Department of Health at
Important: If Item 27 is
any Injury or other trau AROLE 20a. Method of Disposition cemetery, c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) 21. Signature of Funeral Service 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Immediate Cause (Final Exacerbation 8 days **Physician** disease or condition resulting in death) isthma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Por Month Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ohnson 1 Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA ၉ completely filled in by the funeral dir this 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After t Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balti more Caton 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

|  | 1 - For State of N  | Maryland / Department of Health and<br>Certificate of Death  | Mental Hygiene 008 04104   |
|--|---|--|--|
| Physiciar<br>/Medica   | -1/1-/ 4/4  | JOHNSON  | 2. Date of Death Month Day Year FERRUARY 7, 2008 2:00 PM   |
| Examiner<br>Funeral  | 4a. Facility Name (If not institution, give street and number 30 N SE COUR.  5. Social Security Number 6. Sex 7.  |  | N/A  S. B. Date of Birth  9. Birthplace (State or Foreign  |
| Director   | 233-09-2654 1□ M 2☒ F  Usual Residence of Decedent  10a. State 10b. County  | 89 Yrs. Month's Day's Hours Will   | 5-12-1918 MARYLAND   |
| with the Maryli<br>t or 28e-f sho<br>ce I willfied wi  |   | COLUMBIA   | 1 □XYes 2 □ No   |
| 6<br>uffer death with<br>r ffems 23e or<br>deaf must be or   | 8788 SAGE BRUSH WAY  11. Marital Status 12. Was Deceder   | 10f. Zip Code  21045  DESCRIPTION OF THE STATE OF THE STA | 10g. Citizen of What Country?  USA  Specify Yes or No-  14. Race - American Indian,  |
| 1036  ours after d  ral, or iten  Evaluated  | 3 Widowed 4 □ Divorced If Yes, Give Year or Dates   | is? If Yes, specify Cuban, Mexican, Puer   | rto Rican, etc.)  Black, White, etc.  Specify: BLACK   |
| Baltimore, Maryland 21215-0036  Department of Health and Mantal Hygiene. Department of Health and Mantal Hygiene. In the Triem 27 is marked other then "natural", or items 23s or 28s-f show my pripary or other traumatic event, the Medical Examinar must be 1 without at once.  To Re Completed by Funeral Director | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4c)  |  |  |
| F 0 = 5  | 17. Father's Name (First, Middle, Last)   |  | HEALTHCARE ume (First, Middle, Maiden Sumame)  IE MONTGOMERY   |
| Maryland and 2 should be 1 alth and Mental II 27 is marked or ar traumatic eve   | 19a. Informant's Name/Relationship (Type, Print) MAXINE J HARRY   | 19b. Mailing Address (Street and Number or R   | COLUMBIA, MARYLAND 21045   |
| Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic enone.  | 20a. Method of Disposition  1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State  4 ☐ Donation 5 ☐ Otoer (Specify)   | 20b. Place of Disposition (Name of cemetery, crematory or other place)   | Date 20c. Location - City or Town, State 2–12–2008 STEELTON PENNA  |
| Balt<br>permit.<br>Depart<br>Import<br>any inj   | 21. Signature for each service Licensee ONATH   | UBrew 704 N. FRONT ST. S   | AJOR H. WINFIELD FUNERAL HOME<br>STEELTON, PENNA 17113   |
| Physician<br>/Medical  | 23a. Part's. Enter the disease, or complications that caus shork, if heart failure. List only one cause on each immediate Jause (Final disease or fondition resulting in death) | sed the death. Do not enter the mode of dying, such as cardia<br>i line.<br>PTCEMIA  | ac or respiratory arrest, Approximate Interval Between Onset and Death   |
| Examiner   | Sequentially list conditions b.   | as a consequence of):  A F A F A F A F A F A F A F A F A F A   | FAILURE  |
| 58760, licate be executed physician and sthe burial-transit edical Examiner  | resulting in death) Last C. Due to (or a  | as a consequence of):  |  |
| Box 6 Both certiff attending for use as  |   | 2 Fetal death 3 Ectopic pregnancy at time of death 5 Other (specify)   | 23d. Date of delivery  Month Day Year  |
| cords, P.O. wrequires that the depensioned by the should be detached   | Part II. Other significant conditions contributing to death   | but not resulting in the underlying cause given in Part I.   | 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown                                    |
| of Vital Record hysicien: The law requir his certificate has been s I director, page 2 should To Be Completed  |   |  | 24a. Was an autopsy performed?  1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No |
| Of Vita<br>Physicien<br>this certifi<br>ral director   | 25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Impa  27. Manner of Death 28a. Date of In  | tient 2 EP/Outpatient 3 DOA Other: 4 Nursing H   | ath (Check only one)  Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred                                    |
| Division of Vital Records, tall or Attending Physicien: The law requires the reach.  al Director: After this certificate has been signed in by the funeral director, page 2 should be of certification: To Be Completed by   | 1 Natural 5 Pending (Month, D   | njury - At home, farm, street, factory, office   | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State)  |
| he Hospita<br>in 24 hours<br>he Funeral<br>pletely filled  | 29a. Certifier (Check only one)  1 Certifying Physician: To the basis and manner:   | st of my knowledge, death occurred at the time, date and place<br>of examination and/or investigation, in my opinion, death occu<br>stated.  | e, and due to the cause(s) and manner as stated.  urred at the time, date and place, and due to the cause(s)                       |
| To th within To th Comp  | 29b. Signature and title of certifier   | CruZm. D 0 0 3 0   | 3 SFebruary 7, 200   |
| Q  | 30. Name and address of person who completed cause of ROSITA R. CRU   | f death (Item 23er) (Type, Print) BON SI   | ECOURS HOSPITAL  |
| State Registrar  | 31. Date filed (Month, Day, Year) FEB 1 3 2003  | strar's Signature  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 11:47 A M Ann JOYCE Februar 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice Anne Arundel LINTHICUM if Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🔀 F 217-72-1417 Director AUGUST 10, 1963 Marylanc Usual Residence of Decedent filed within 72 hours after death with the Maryland I Hygiene. 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 No Directo Maryland Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 103 Central 21061 venue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 ☐ Widowed 4 ▶ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Ethel Mae William 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Kristi Miller Matthews 1557 Hanover, MD 21076 TOWN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State February 13,2008 Harover, MD Arden't Commation Services 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardest Cremedical Services 21. Signature of Funeral Service Licensee Jama C. Hardestin M-01197 7522 Conselled Drive Suite A

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Drive Suite N. Hanover, MD 21076 Immediate Cause (Final disease or condition resulting in death) BRAIN Physician months /Medical Due to (or as a consequence of): **Examiner** Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical 26. Place of Death (Check only one) Be TATE HERICE Other: 4 Nursing Home 5 Residence 6 SOther (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

DHMH 17 Rev 1/2001

Registrar

Paturent Pkwy Columbia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward I Lee MD

31. Date filed (Month, Day, Year)

11065

Little

92. Registrar's Signature

|   |  |                   | State Amend Item  | n 26 per dr.  | , g876,6                   | 2414249844  | <b>D</b> eath         |                                       | g. No. 2008                                 | 04106  |  |
|---|--|-------------------|---|---|----------------------------|---|-----------------------|---------------------------------------|---|--|--|
| Physiciar   |  | n                 | Decedent's Name (First, Middle, Last)  EMANUEL  |   |                            | KATZEN  |                       |                                       | 8 2008                                      | 3. Time of Death 3:05 P M                        |  |
| /Medical  |  |                   | 4a. Facility Name (If not institution, give   | e street and number)  | MILL                       |   | or Location of Death  | FEBRUARY                              | 4c. County of Deat                          |  |  |
| Examiner  |  |                   | 6 BARBICAN WAY  | · ·   |                            | BALT  | IMORE                 |                                       | BALTI                                       | MORE   |  |
| Fun<br>Dire   | eral<br>ctor                                       |                   | 214-22-3/25   | ex<br>M_M 2□F 7. Age (//<br>80  | n yrs. last birthda<br>Yrs | Months Davs   |                       | 8. Date of Birth (Month, Day, 02/26/1 | 9. Birt<br>927                              | hplace (State or Foreign<br>buntry)<br>MD        |  |
| and   | 46   |                   | Usual Residence of Decedent  10a. State 10b. County   | 10  | Dc. City, Town or          | Location  |                       |                                       |   | 10d. Inside City Limits                          |  |
| Maryl<br>-f sho   | fied a   | ţo                | MD BALT   | IMORE   |                            | BALTIMORE   |                       |                                       |   | 1 □ Yes 2 No                                     |  |
| th the  | notir  | Director          | 10e. Street and Number  |   | 10f. Zip Code              |   | 10                    | g. Citizen of What Co                 | -   |  |  |
| ath wi  | ust b  |                   | 6 BARBICAN WAY  |   |                            |   | 21208                 |                                       | US  |  |  |
| Maryland 21215-0036 at 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 Is marked other than "natural"; or items 23a or 28a-f show | event, the Medical Examiner must be notified at    | by Funeral        | 11. Marital Status  1 □ Never Married 2 → Married  3 □ Widowed 4 □ Divorced   | 12. Was Decedent Eve<br>Armed Forces?<br>1 ☑ Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates: | WWII                       | 3. Was Decedent of<br>If Yes, specify Cut<br>1 ☐ Yes 2 🗖 No |                       | ecity Yes or No-<br>Rican, etc.)      | 14. Race - Ame<br>Black, Whit<br>Specify: W |  |  |
| <b>5-0</b> 72 hc 72 hc  | dical  | eted              | 15. Decedent's Ed<br>(Specify only highest gra  |   | 1 (G                       | cedent's Usual Occu   | e during most of work | king                                  | 6b. Kind of Business                        | /Industry  |  |
| d 21215-<br>filed within 72<br>Hygiene.<br>other than "na   | e Me   | Completed         | Elementary/Secondary (0-12)   | College (1-4or 5+)  |                            | e. DO NOT use retire<br>LECTRICAL                           | •                     |                                       | US GOVERN                                   | MFNT   |  |
| filed v   | aut, #   |                   | 17. Father's Name (First, Middle, Last)   |   |                            | LOTRIONE  |                       | e (First, Middle, N                   |   | 7712111  |  |
| Irylan<br>should be<br>nd Mental<br>marked o  |  | To Be             | MORRIS K  |   |                            | ١   | REBE                  | CCA CHERKASSKY                        |   |  |  |
| laryla<br>2 should<br>and Mer<br>Is marke   | other traumatic                                    | _                 | 19a. Informant's Name/Relationship (  | Type. Print)  | i                          | ,   |                       |                                       | City or Town, State,                        | Zip Code)  |  |
|   | her tra  |                   |   | WIFE  |                            | BARBICAN sposition (Name of                                 |                       |                                       |   | T Otata  |  |
| Baltimore, permit. Pages 1 ar Department of Hea   | -  |                   | 20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify   | Removal from State  | ANSHE"                     | MUNAH<br>AIM  | 02/10                 | 0/2008                                | 20c. Location - City or<br>BALTIMORE        | , MD   |  |
| Balt permit. Departr  | any injury o<br>once,                              |                   | 21. Signature of Funeral Service Licer  | With  |                            |   | STERSTOWN             | ROAD -                                |   | ., INC.<br>, MD 21208                            |  |
| Physic<br>/Med<br>Exam  | lical<br>iner                                      | Examiner          | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, lary hearts to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of): |   |                            |   |                       |                                       |   |  |  |
| Box<br>ath cer  | be detached for use as the burial-transit          | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome pf<br>1 □ Live birth 2 [<br>4 □ Pregnant at tin<br>9 □ Unknown       | Fetal death                | 3 □Ectopic pregnan<br>5 □ Other (specify)                   | су                    |                                       | 23d. Date of de<br>Month                    | livery<br>Day Year                               |  |
| s that  | e deta   | by Pr             | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  |   |                            |   |                       |                                       |   |  |  |
| Records, ne law requires to has been signe  | d bluc   | ed b              | Verphose Vascular dedada 1 Yes 2 No 3 Probably 4 Horknow  |   |                            |   |                       |                                       |   |  |  |
| law ra  | 2 sh   | Completed         | * treal   | Febrello  | reen                       |   |                       | 24a. Was ai<br>autops                 | y prior to                                  | utopsy findings available completion of cause of |  |
| The The cate h  | rector, page 2 should                              | Con               | strane  |   | •                          |   |                       | perförr<br>1⊟ Yes 2                   | ned? death?<br>2☑No 1☐Ye                    | s 2□No   |  |
| Vital<br>sician: 1<br>certificat  | rector   | Be                | 25. Was case referred to medical examiner? Hospital: Cother:  |   |                            |   |                       |                                       |   |  |  |
| VISION OF VITA Attending Physician: r death. ector: After this certific   | er this<br>eral di                                 | 2                 | 27. Manne Leath 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred   |   |                            |   |                       |                                       |   | ecity)   |  |
| ion<br>Ith.<br>Ith.<br>Ith.   | e fune   | atior             | 1   |   |                            |   |                       |                                       |   |  |  |
| Division or all or Attending Physics after death.   | completely filled in by the funeral director, page | Certification:    | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                            |   |                       |                                       |   | lural Route Number,                              |  |
| Div To the Hospital or A within 24 hours after To the Funeral Dire  | pletely fille                                      | Medical (         | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |                            |   |                       |                                       |   |  |  |
| To ti<br>withi  | Tot  | Z                 | 29b. Signature and title of certifier   | Nalmon  | ) uc                       |   | 005 (89               | 26                                    | 9d. Date signed ( <i>Mon</i>                | 8  |  |
| (10)  |  |                   | 30. Name and address of person who  | 1000  | 2700                       | pe, Print)<br>Qua   | en Lac                | cer gr                                | - Bher                                      | o MD   |  |
| R   | Sta<br>egistr                                      |                   | 31. Date filed (Month, Day, Year)  FEB 1 3 200  | 62. Registrar's   | s Signature                | 34%   |                       |                                       |   |  |  |

DHMH 17 Rev 1/2001

IT 23 Holey as will F

|                                 |   |                  | For   | State of Ma   | aryland                          | -                      |   |                               |   | /lental Hy                          | /giene                            | 2000                                      | 0110   |
|---------------------------------|---|------------------|---|---|----------------------------------|------------------------|---|-------------------------------|---|-------------------------------------|-----------------------------------|---|--|
| _                               |   |                  | 1 - State<br>Registrar  |   |                                  | Cer                    | tificate                                    | of De                         | eath  |                                     | Reg. No.                          | 2000                                      | ) 0410   |
| п                               | Physic  | an               | 1. Decedent's Name (First, Middle,  | Last)   |                                  | 1 .                    |   |                               |   | 2. Date of D<br>Month               | eath<br>Day                       | Year                                      | 3. Time of Death                                 |
|                                 | /Medi   |                  | JANET   | H   |                                  | 14                     | UNIT  | IK                            | A   | FEBRU,                              |                                   |   | 5 1240 PM  |
|                                 | Exami   | er               | 4a. Facility Name (If not institution,  | give street and number)   |                                  |                        | 4b. City, To                                | wn, or Lo                     | ocation of Death                                |                                     | 4c.                               | County of Dea                             | th   |
|                                 |   |                  | JOHNS HOPKING B   |   |                                  |                        | E   |                               | Timou   |                                     |                                   |   |  |
|                                 | Funeral<br>Director   |                  | 5. Social Security Number 219-14-0508  Usual Residence of Decedent  | 5. Sex 7. Ag<br>1   | e (In yrs. Ia<br>82              | st birthday)<br>Yrs.   | If Under 1 Months C                         |                               | f Under 24 Hrs.<br>Hours Min.                   | 8. Date of Bi<br>(Month, D<br>Feb 2 | rth<br>ay, Yea <i>r)</i><br>1,19  | Co  | thplace (State or Foreigr<br>ountry)<br>Maryland |
|                                 | and and   |                  | 10a. State 10b. County  |   | 10c. City,                       | Town or Loc            | cation                                      |                               |   |                                     |                                   |   | 10d. Inside City Limits                          |
|                                 | ne Maryl<br>8a-f sho<br>otified a   | ector            |   | imore   | Ва                               | ltimo                  |   |                               |   |                                     | 10 000                            |   | 1 ☐ Yes 2X No                                    |
|                                 | th with the 23a or 2 ust be no  | Funeral Director | 8307 Orchard Drive  |   |                                  | 10f. Zip Code 21222    |   |                               |   |                                     | 10g. Citizen of What Country? USA |   |  |
| 36                              | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | by Fune          | 11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced   | 12. Was Decedent Armed Forces?  1 Yes 2 1 If Yes, Give Year or Dates:   |                                  |                        | Vas Deceder<br>f Yes, specify<br>☐ Yes 2    |                               | anic Origin? (Sp<br>Mexican, Puerto<br>Specify: | ecify Yes or N<br>Rican, etc.)      |                                   | 14. Race - Ame<br>Black, Whit<br>Specify: |  |
| 21215-0036                      | "natural  | Completed t      | 15. Decedent's<br>(Specify only highest   | Education   |                                  | (Give                  | ent's Usual (<br>kind of work<br>OO NOT use | done dur                      | on<br>ring most of worl                         | king                                | 16b. Kir                          | nd of Business                            | /Industry  |
| 121                             | withir<br>lene.<br>than<br>the Me   | ш                | Elementary/Secondary (0-12)<br>12th   | College (1-4or 5  | 5+)                              | Nur                    |   | (Guilea)                      |   |                                     | I                                 | Health                                    | ı  |
| d 2                             | rould be filed v<br>I Mental Hygie<br>narked other t  |                  | 17. Father's Name (First, Middle, L   | ast)  |                                  |                        |   | 18                            | 8. Mother's Nam                                 | e (First, Middle                    | e, Maiden                         | Surname)                                  |  |
| Maryland                        | ld be<br>ental<br>ked c   | To Be            | Albert H. Th  | ursby   |                                  |                        |   |                               | Dori  | s H. H                              | Rau                               |   |  |
| ary                             | 2 should I<br>and Men<br>is marker  | -                | 19a. Informant's Name/Relationshi   | (Type. Print)   |                                  | 19b. Mailin            | g Address (S                                | treet and                     | d Number or Ru                                  | ral Route Num                       | ber, City or                      | r Town, State,                            | Zip Code)  |
|                                 | 1 and 2<br>Health a<br>em 27 is   |                  | James T. Kur  | tyka /son   |                                  | 83                     | 07 Or                                       | cha                           | rd Dri  | ve Bai                              | Ltimo                             | ore MD                                    | 21222  |
| Je,                             | ss 1 a  |                  | 20a. Method of Disposition  |   | 20b. Pla                         | ace of Dispo           | sition (Name<br>natory or othe              | of<br>er place)               | 2   | Date                                | 20c. Lo                           | cation - City or                          | Town, State                                      |
| E                               | permit. Pages<br>Department of I<br>Important: If Ite<br>any injury or of<br>once.  |                  | 1 ☐ Burial 2 <b>X</b> Cremation : 4 ☐ Donation 5 ☐ Other ( <i>Sp</i>  |   |                                  |                        | Ćrem  |                               | ry 2/0  | 9/08                                | Ba                                | altimo                                    | re MD  |
| Baltimore,                      |   |                  | 21. Signature of Funeral Service L  | Rev   | 7                                |                        | Name and                                    |                               | 30  |                                     |                                   |   | to. MD<br>x 21221                                |
|                                 | \$ 5 m  |                  | 23a. Part1. Enter the disease, or o shock, or heart failure. List o   | omplications that caused  | the death.                       |                        |   |                               |   |                                     |                                   |   | Approximate<br>Interval Between                  |
|                                 | Physician   |                  | Immediate Cause (Final disease or condition   |   |                                  |                        |   |                               | URE   |                                     |                                   |   | Onset and Death                                  |
| 1                               | /Medical  |                  | resulting in death)   | as a consequence of):   |                                  |                        |   |                               |   |                                     |                                   |   |  |
|                                 | Examiner  |                  | Sequentially list conditions  | D   | END STAGE COPD                   |                        |   |                               |   |                                     |                                   | 2 WEEKS                                   |  |
|                                 | P. #  | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as   | Due to (or as a consequence of): |                        |   |                               |   |                                     |                                   |   |  |
| V                               | cate be executed<br>obysician and<br>the burial-transit   | Examiner         | that initiated events resulting in death) Last  | as a consequence of):   |                                  |                        |   |                               |   |                                     |                                   |   |  |
| 8760,                           | be ey   | al E             | Due to (of as a consequence of).  |   |                                  |                        |   |                               |   |                                     |                                   |   |  |
| or Vital Records, P.O. Box 6870 | physic the  | dical            |   | <b>d</b>  |                                  |                        |   |                               |   |                                     |                                   |   |  |
|                                 | requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit   | Physician/Me     | IF FEMALE: 23b. Was decedent pregnant in the past 12 modits? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown   | 23c. If yes, outcome<br>1 □ Live birth<br>4 □ Pregnant a<br>9 □ Unknown | 2 Fetal                          | death 3□               | Ectopic preg<br>Other (spec                 |                               |   |                                     | 2                                 | 23d. Date of de<br>Month                  | elivery<br>Day Year                              |
|                                 | ires that the de<br>signed by the<br>be detached  |                  |   |   |                                  |                        |   |                               |   |                                     | o the cause of death?             |   |  |
|                                 | w requires<br>been sign<br>should be  | ed by            |   |   |                                  |                        |   |                               |   | 152                                 | Yes 2[                            | □No 3□P                                   | robably 4 Unknown                                |
|                                 | e law<br>has b  | Completed        |   |   |                                  |                        |   |                               |   | per                                 | opsy<br>formed2                   | prior to death?                           |  |
| ta                              |   |                  | 25. Was case referred to medical  |   |                                  |                        |   |                               | 26. Place of Dea                                | 1 Yes                               |                                   | 1 ☐ Yes                                   | s 2 No   |
| Š                               | Physiclan:<br>this certific<br>ral director,  | To Be            | examiner?<br>1 ☐ Yes 2 ☐ No   | Hospital: 1 Inpatie   | ent 2□E                          | R/Outpatien            | t 3 DOA                                     | Other:                        |   |                                     |                                   | 6 □Other (Sne                             | ecify)   |
|                                 | ding<br>h.<br>After<br>funel  | tion: T          | 27. Manner of Death  1 Natural 5 Pending investige  | 28a. Date of Inju<br>(Month, Da   |                                  | 28b. Time of<br>Injury |   | . Injury a<br>Work?<br>1 ☐ Ye |   | 28d. Describe                       |                                   |   | */   |
| <b>Division</b>                 | or Attending<br>after death.<br>Director: After<br>in by the fune   | ertification:    | 2 ☐ Accident investigs 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin   | t be 28e. Place of inj  | ury - At hon<br>tc. (Specify)    | ne, farm, str          |   |                               |   |                                     | (Street and<br>own, State         |   | ural Route Number,                               |

Division or Vital Records, P.O. Box 68760. To the Hospital of within 24 hours af To the Funeral D completely filled in

State

29a. Certifier

29b. Signature ap

Medical

30. Hame and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) RICHARDSON,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Registrar

|                     |  |                 | State of Maryland / De State of Maryland / De State of Maryland / De Proposition / De Propo | partment of Health and N<br>18 Th<br>ertificate of Death   | Mental Hygie                     | ne<br>2008                    | 04108                           |  |  |  |  |
|---------------------|--|-----------------|--|--|----------------------------------|-------------------------------|---------------------------------|--|--|--|--|
| Ī                   | THE  |                 | Decedent's Name (First, Middle, Last)  |  | 2. Date of Death                 |                               | 3. Time of Death                |  |  |  |  |
| R                   | Physicia<br>/Medic   |                 | Kenneth D. Lewis   |  | Month<br>Feb. 10                 | Day Year 0 2008               | 4:45 P M                        |  |  |  |  |
| 100                 | Examin   |                 | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death   | 1                                | 4c. County of Death           |                                 |  |  |  |  |
|                     |  |                 | MD Masonic Home  | Cockeysville   |                                  | Bal                           | Ltimore                         |  |  |  |  |
|                     | Funeral  |                 | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd.  | Months Days Hours Min  | 8. Date of Birth (Month, Day, Ye | 9. Birth                      | nplace (State or Foreign intry) |  |  |  |  |
|                     | Director   |                 | 213-32-7890  |  | Sept. 1                          | 1935 N                        | 1D                              |  |  |  |  |
|                     | and w  |                 | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or   | Location   |                                  |                               | 10d. Inside City Limits         |  |  |  |  |
|                     | Maryl<br>f sho<br>ied a  | Director        | MD Baltimore Cock  | eysville   |                                  |                               | 1 □Yes 2 □ No                   |  |  |  |  |
|                     | the 28a-   |                 | 10e. Street and Number   | 10f. Zip Code  | 10g.                             | Citizen of What Cou           | untry?                          |  |  |  |  |
|                     | 3a or  |                 | 300 International Circle   | 21030  |                                  | USA                           |                                 |  |  |  |  |
|                     | death<br>ms 2  | Funeral         | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?   | Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto                     | pecify Yes or No-                | 14. Race - Amer               |                                 |  |  |  |  |
| 9                   | after<br>or Ite  | 교               | 1 □ Never Married 2 □ Married   1 □ Yes 2 □ No   If Yes, Give  | 1 ☐ Yes 2 No Specify:  | Trican, etc.)                    | Black, White                  | white                           |  |  |  |  |
| 93                  | ours<br>tral",   | d by            | 3√ Widowed 4 Divorced Year or Dates:   |  |                                  |                               |                                 |  |  |  |  |
| Maryland 21215-0036 | 72 h<br>"natu<br>dical   | To Be Completed | (Specify only highest grade completed) (G  | cedent's Usual Occupation<br>ive kind of work done during most of worl<br>e. DO NOT use retired) | king   16t                       | o. Kind of Business/I         | ndustry                         |  |  |  |  |
| 12                  | within   |                 | Elementary/Secondary (0-12) College (1-4or 5+)   | ,  |                                  | D - 1 1                       | Casia                           |  |  |  |  |
| 7                   | illed v<br>Hygie<br>ther i   |                 | 12 n/a 17. Father's Name ( <i>First, Middle, Last</i> )  | Route Salesman  18. Mother's Nam   | ne (First, Middle, Mai           | Baked<br>den Surname)         | Goods                           |  |  |  |  |
| ano                 | 2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at   |                 | Carlton Lewis  | Virgi  | nia (unkno                       | own by int                    | formant)                        |  |  |  |  |
| <u></u>             | shoul<br>nd Me<br>mark   |                 |  | ailing Address (Street and Number or Ru  |                                  |                               |                                 |  |  |  |  |
|                     | and 2 sealth an n 27 is  |                 | Lawrence A. Lewis, Sr./son 30  | 2 Highland Dr. #10   | 2, Glen Bu                       | urnie, MD                     | 21061                           |  |  |  |  |
| ē,                  | s 1 and if Health Item 27 other tr   |                 | 20a. Method of Disposition 20b. Place of Di  | sposition (Name of crematory or other place)   | Date 20d                         | c. Location - City or         | Town, State                     |  |  |  |  |
| altimore,           | permit. Pages 1 and 2 should<br>Department of Health and Men<br>Important: If Item 27 is marke<br>any Injury or other traumatic<br>once.   |                 | 1 Buriai 2 Cremation 3 Hemoval from State  | rematory 2/14  | /08 Cat                          | tonsville                     | , MD                            |  |  |  |  |
| alti                | permit. Departm Importal any Inju  |                 | 21. 9 may of Funda Stryic Tenses 7)  | 22. Name and Address of Facility   |                                  | nor Voller                    | . Inc                           |  |  |  |  |
| m                   | o a li o   |                 | Bryan W. Clary   | Lemmon Funeral Hom<br>10 W. Padonia Rd.,   | Timonium                         | MD 2109                       | 3                               |  |  |  |  |
| H                   | 100  |                 | 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between  |  |                                  |                               |                                 |  |  |  |  |
| 1                   | Physician  |                 |  | elin went  |                                  |                               | Onset and Death                 |  |  |  |  |
|                     | /Medical   |                 | resulting in death)  Due to (or as a consequence of):  | 3  |                                  |                               | 1.4                             |  |  |  |  |
| ø                   | Examiner   | l. I            | Sequentially list conditions. b. Coroney as  | elin Grent<br>ten Disesse<br>n Vasalon Di  |                                  |                               | Jeus.                           |  |  |  |  |
| 1                   | g ti   | Examiner        | Sequentially list conditions, if any list of the course, the course is the course of the course. Enter Underlying Cause (Disease or injury that initiated events  c. A Dan Suleot  | - 1/ . 0 . 7   | ~ 0                              |                               | (1111)                          |  |  |  |  |
|                     | cate be executed oblysician and the burial-transit   | хаш             | that initiated events resulting in death) Last  C. Due to (or as a consequence of):  | er abalen ju   | wese                             |                               | gians.                          |  |  |  |  |
| 8760,               | be e)<br>ician<br>buria  | ᄪ               |  |  |                                  |                               | ·                               |  |  |  |  |
| 687                 | icate<br>physi<br>s the I  | dical           | d  |  |                                  |                               |                                 |  |  |  |  |
| Box (               | death certific<br>attending pl   | Physician/Me    | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy  | _  |                                  | 23d. Date of deli             | ivery                           |  |  |  |  |
|                     | death<br>atter   | ciai            | in the past 12 months?  1 Yes 2 No   | 3 ☐ Ectopic pregnancy<br>5 ☐ Other (specify)   |                                  | Month                         | Day Year                        |  |  |  |  |
| o.                  | that the ded by the detached   | hysi            | 9 Unknown N/A 9□Unknown  |  |                                  |                               | .,                              |  |  |  |  |
| ·                   | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit   | by P            |  |  |                                  |                               |                                 |  |  |  |  |
| ğ                   | w requires that<br>been signed I<br>should be det  | Completed b     | Diabetes Welliten, Congestine  | port Faulure,  | 1 ☐ Yes                          | 2 □ No 3 □ Pr                 | obably 4 Unknown                |  |  |  |  |
| Records, P.O.       | aw re  |                 | Hypertersin COPP, Sleep V  | Jonen, Electolyt   | 24a. Was an autopsy              | 24b. Were au                  | topsy findings available        |  |  |  |  |
| m<br>m              | The I  | mo;             | introduce Valunden Deut D  | iseal  | performe                         |                               | • - 1                           |  |  |  |  |
| ita                 | ian:<br>ertifica<br>ctor, I  | Be              | 25. Was case referred to medical examiner?   | 26. Place of Dea   | th (Check only one)              |                               |                                 |  |  |  |  |
| <u>&gt;</u>         | hysic<br>his ce<br>I dire  | 은               | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa  |  | ome 5□Residenc                   |                               | cify)                           |  |  |  |  |
| Division or Vital   | ing P<br>After t   | ii o            | 27. Manner of Death 28a. Date of Injury 28b. Tim  1   Natural 5 □ Pending (Month, Day Year) Injury   | ry Work?   | 28d. Describe how                | injury occurred               |                                 |  |  |  |  |
|                     | tendi<br>eath.<br>tor: /<br>the fo   | cati            | 2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury 4t home farm   | M 1 Yes 2 No   | 006 1 10 (01                     | -1 Al                         | De As March                     |  |  |  |  |
|                     | or At<br>ifter d<br>Direc<br>in by   | Certification:  | 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home, farm building, etc. (Specify)   | street, factory, office  | City or Town, S                  | et and Number or Ru<br>State) | irai Houle Number,              |  |  |  |  |
|                     | Hospital<br>24 hours a<br>Funeral I  | Medical Cel     | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |                                  |                               |                                 |  |  |  |  |
|                     | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely illied in by the funeral director, page 2   |                 | (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                                  |                               |                                 |  |  |  |  |
|                     | Fo the within Fo the complex c | Me              | 29b. Signature and title of certifier  | 29c, License number  | 29d                              | . Date signed (Mont           | h, Day, Year)                   |  |  |  |  |
|                     | ->-0   | 2/11/08         |  |  |                                  |                               |                                 |  |  |  |  |
| 1                   | 7  |                 | 30. Name and address of person who completed cause of death (Item 23a) (Ty   | pe, Print)   |                                  | /                             |                                 |  |  |  |  |
| 4                   | + 1  |                 | RUBGET LIBERTS, MS. 300 Internation  | Marche Corleges  | ele, mil                         | 21030                         |                                 |  |  |  |  |
|                     | Sta  |                 | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | Annak :  |                                  |                               |                                 |  |  |  |  |
|                     | Regist   | ar              | FEB 1 3 2008   |  |                                  |                               |                                 |  |  |  |  |

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2008 04109

| ernard ivledalry  | 1              | For State  For State  Certificate of Death  egistrar   | Reg   | No.                                  |  |
|---|----------------|--|---|--------------------------------------|--|
| Physicia  | in/            | . Decedent's Name (First, Middle,Last)   | 2. Date of Death<br>Month [<br>February 11    | Day Year                             | 3. Time of Death<br>2130 hrs   |
| ા Exami   |                | Bernard John Medairy, III  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Deat   |   | 4c. County of Death                  |  |
|   |                | 511 Chesapeake Avenue Annapolis  |   | Anne Arundel                         | La la constanta de la constant |
| Funeral<br>Director   |                | 5. Social Security Number 220-52-4219 6. Sex 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hi Months Days Hours Mi   | rs. 8. Date of Birth<br>in. June 17           | (MM/DD/YYYY) 9. Birl<br>Foreig<br>Co | thplace (State or<br>in Baltimore,<br>untry) Maryland  |
| ow any  | ſ              | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Maryland Anne Arundel Co. Annapolis   |   |                                      | 10d. Inside City Limits  1 Yes 2 No  |
| the Maryland is or 28a-f show any utilied at once.  | Director       | 10e. Street and Number 511 Chesapeake Ave.#2  10f. Zip Code 21403  | Ι,  | g. Citizen of What Cou<br>United Sta | •  |
| r death with  | — L            | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No specify:   | Specify Yes or No-<br>to Rican, etc.)         | White, etc.                          | ican Indian, Black,  |
| ours afte<br>atural",<br>xaminer  |                | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use most of working life. DO NOT use most of working life.   |   | 16b. Kind of Business/               | Industry   |
| 5-0036<br>led within 72 hours afte<br>Hygiene.<br>other than "natural",<br>the Medical Examiner   | Completed by   | Elementary/Secondary (0-12) College (1-4 or 5+) 12 02 Disabled   |   | Disab                                | led  |
| 21215-0036 und be filed within 7 Mental Hygiene. marked other than c event, the Medica  |                | 17.1 atticles Natified Wildered East/  | me (First, Middle, M<br>ia Beach              | aiden Surname)                       |  |
| 2121<br>2121<br>ould be f<br>Mental<br>marke<br>c event   | To Be          | 19a. Informant's Name/Relationship (Type, Print) (Father) 19b. Mailing Address (Street and Number of   | or Rural Route Num                            |                                      |  |
| , MD<br>and 2 sho<br>ealth and<br>eem 27 is   |                | Mr. Bernard John Medairy, Jr. 229 Dunkirk Road  20a. Method of Disposition (Name of cemetery,  | Baltimor                                      | e, Marylan<br>20c. Location - City o |  |
| Baltimore, MD oemit. Pages 1 and 2 sho Department of Health and Important: If item 27 is njury or other traumati  |                | 1 Burial 2 Cremation 3 Removal from State Evans Funeral Chapel Fel   | b. 14, 20                                     |                                      | t Hill,MD.   |
| Balt<br>permit.<br>Departi<br>Import  |                | 21. Signature of Funeral Service Ligensee Gan A 22. Name and Address of Facility Peaceful Alternat: 2325 York Road   | ives Fune<br>Timoniu                          | ral&Cremat<br>m, Marylan             | ion Ctr., P.A<br>d 21093   |
| hysician<br>Medical   |                | 232 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure List only one cause on each line.  Immediate Cause (Final disease a. Complications of cancer                                 | ic or respiratory arre                        | est, snock, of near                  | Between Onset and<br>Death   |
| _xaminer  |                | Immediate Cause (Final disease or condition resulting in death)  a. CHIPTICALIONS OF CHICE!  Due to (or as a consequence of):  |   |                                      |  |
|   | ıer            | Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):   |   |                                      |  |
| ted<br>1<br>Insit   | Examine        | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  |   |                                      |  |
| e execu<br>cian and<br>rial - tra   | Medical        | X UNPENDED AMENDED 27, perME, g876, 2/25/08 TT   |   |                                      |  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and compleably filled in whe fineral director, nage 2 should be detached for use as the burial - transit | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)  | gnancy  | 23d. Date of delive<br>Month         | ery<br>Day Year  |
| hat the deat ed by the at letached for  | by Phys        | 1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                                      | to the cause of death?   |
| ords, P iw requires t as been sign  | Completed b    |  | 24a. Was<br>autop                             | an 24b. Were prior t death           |  |
| Rec<br>The la<br>ficate h   | l E            | 26.Place of Death (Ch.   | 1 Yes   | 2 No 1                               | Yes 2 No   |
| 'ital<br>sician:<br>is certil   | Be             | examiner?   Hospital: 1   Inpatient 2   FR/Outpatient 3   DOA   Other 4   No.  | ursing Home 5                                 | Residence 6 🗸 Ot                     | her: Scene   |
| n of V<br>ding Phys.<br>J. After thi  | on: To         | 1 Ves 2 No Impact 2 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  1 X Natural 5 Pending  |   | how injury occurred                  |  |
| Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate thours after death. To the Fural Director: After this certificate has been signed by the attending prompleted filled in by the filmeral director, name 2 should be detached for use as the  | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   | 28f. Location (<br>or Town,                   |                                      | Rural Route Number, City   |
| To the Hospir within 24 hour Pro the Funer Completely fill  | Medical Ce     | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. | , and due to the cau<br>red at the time, date | and place, and due to                | the cause(s)   |
| <b>1</b>  | Me             | 29b. Signature and title of certifier  29c. License number  O.C.M.E.   |   | February 12, 2                       |  |
| 19  |                | 30. Name and address of person who completed cause of death (Item 23a)  Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore.   | , MD 21201                                    |                                      |  |
|   | State          | 31. Date filed (Month, Day, Year) 33. Registrar's Signature  |   |                                      |  |
| Regi  | stra           | LER TO TOO MANAGEMENT  |   |                                      |  |

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] 8 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month O2 2000 **Physician** Raymond 08 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Sykesville Carrol1 Transitions Health Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Aug 16, Birthplace (State or Foreign Country)
 K I 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**∑**M 2□F 403-32-2356 76 Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at MD Carrol1 Svkesville 1 Yes 2 No Director 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 5476 Mineral Hill Road 21784 USA Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1X Yes 2□Nº Korea If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) veterinary science Elementary/Secondary (0-12) veterinarian 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Ida Louise Sans Thomas Joseph Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a important: if item 27 ie any injury or other trat once. 5476 Mineral Hill Rd., Sykesville, MD 21784 Patricia Murphy (spouse) 20b. Place of Disposition (Name of cometery, crematory or other place)
Garrison Forest Vet. Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-13-08 Owings Mills, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Gaige Spargent of erbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sensis Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner enous nont Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete has t lirector, page 2 s autopsy performed? 2₽No 1 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes 2 EkNo this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1. Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation death. Director: / 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de: To the Funeral Directo completely filled in by th 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 810 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminister HMOUN 31. Date filed (Month, Day, Year) \_Registrar's Signature State Registrar 3

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Then 17 per fh 9876 2-19-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 3:30 February 9, /Medical JAMES STEPHEN MIDGLEY 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Days Months 1 🛣 M 2 🗆 F Yrs 010-30-4819 Director 69 29, 1938 April England Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ms 23a or 28a-f st must be notified 1 ☑ Yes 2 ☐ No Directo Maryland Montgomery Germantown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a 19161 St. Johnsbury Lane 20876 United States Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates: 1959–1989 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 🔀 No Specify: White Specify. þ 3 Widowed 4 Divorced "natural"; er than "natur, the Medical I Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygene. Item 27 is marked other than Federal Government 4 Captain 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilfred Midgley Margaret Thompson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth K. Midgley / Wife 19161 St. Johnsbury Lane, Germantown, MD 20876 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 'Department of H Important: If ite any injury or of once. February 12 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Crematorium 2008 Bethesda, Maryland
22. Name and Address of Facility to bert A. Tumphrey Funeral Home/
Rockville, Inc., 300 West Montgomery Avenue,
Rockville, Maryland 20850-2805 4 ☐ Donation 5 ☐ Other (Specify) Mongomery Crematorium 21. Signature/of Funeral Service/Licensee M01473 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or heart failure Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Completed by Physician/Medical the attending p SS IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown by the a 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 rector, page 2 autopsy performed 25. Was case referret to medical examiner? 1 Yes 2 No or Attending Physician: Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; / completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) MD 51610 108 noxl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael A. Tolino, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 3 Registrar

DHMH 17 Rev 1/2001

State Registrar Raman R. Tuli,

31. Date filed (Month, Day, Year)

M.D.

FEB 1 3 2008

₽egistrar's Signature

10810 Darnestown Road, #202, Gaithersburg, Maryland 20878

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 4:45 A. 9, 2008 February Helen I. Norris 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Holly Hill Nursing Home Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Auq. 14, 1907 Maryland 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, Months 1 ☐ M 2 ☑ F 100 213-01-5387 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Maryland Baltimore Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21286 531 Stevenson Lane 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 2XXVIo 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2XXNo 3XXVidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Washington Jones Maud Purdy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 531 Stevenson Lane, Towson, Maryland 21286 Holly Hill Nursing Home 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 2/12/2008 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, 3631 Falls Road, Baltimore, Mary 21. Signatur of Tuneral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or deart failure. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardidvocular iteriosclertic eun) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Due to (or as a consequence of) 23d. Date of delivery 3 Ectopic pregnancy leath Month Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? ing in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 **X**No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 28b. Time of 28d. Describe how injury occurred

Physician /Medical **Examiner** 

Department of Health a Important: If item 27 is any Injury or other trau

Pages 1

Physician

/Medical

Examiner

**Funeral** 

Director

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r items 23a or 2 iner must be n death with

"natural", or iten edical Exaπiner

the Medical

traumatic event,

2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or iter

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division or Vital Records,

certificate be

Director

Funeral

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Completed

Examiner the burial-tran attending physician Physician/Medical use as signed by the a page 2 should has been certificate After this funeral To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After

þ

Completed

Be

Certification:

Medical

29a. Certifier

| FEMALE:<br>3b. Was decedent pregnant<br>in the past 12 months?<br>1 □ Yes 2 No<br>9 □ Unknowh | 23c. If yes, outcome pf pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown |
|---|--|
| art II. Other significant condition   | ns contributing to death but not result  |

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

17041

| one)               | and manner stated. |
|--------------------|--------------------|
| 29b. Signature and | title of certific  |
| ) r                | ta . Di            |

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

FEBRUARY 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YORK ROAD \$38 LUTHERVILLE MY MARC I. LEAVEY 1205

State Registrar 31. Date filed (Month, Day, Year) 2008 FEB 13



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1tem 20b per per 1h 8876 2-20-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 11:30a<sup>M</sup> CLARENCE LEANDER POULSON February 10 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GENESIS HEALTH CARE-RANDALLSTOWN RANDALLSTOWN BALTIMORE CO If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) VIRGINIA 8. Date of Birth (Month, Day, Year)
Mar. 23 1914 Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1X MM 2 □ F Director 93 227-14-6897 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show at 1 ☐ Yes 2 No must be notified Director BALTIMORE RANDALLSTOWN MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , 23a c 21133 U.S.A. 8900 FLAGSTONE CIRCLE Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2XXXNo Specify. Specify: BLACK þ 3k Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FORKLIFTER/BARBER **SEAGRAMS** 12th grade other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Is marked BEATRICE POULSON ပ္ JOHN POULSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 Is any Injury or other trau 8900 Flagstone Circle, Randallstown, Md., 21133 Linda Ridout-Foster/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place pk 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 02-15-08 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee, 22 Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Darbara Brow 1206 W NORTH AVENUE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician da disease or condition resulting in death) neum on 3 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and s the burial-tran: Due to (or as a consequence of): Records, P.O. Box 68760 Completed by Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2□No the 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed? certificate 1□ Yes 2□No Division or Vital To the Hospital or Attending Physiclan: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Other: Desidence 6 Other (Specify) 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After (Month, Day Year) 5 Pending Investigation Natural Injury 1 ∏Yes 2 ∏No 2 Accident after death | Director; ,d in by the f 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainly stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 1121046 -cr Haymman of Fany Ref Ball MD H22) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Registrar's Signature Year) State 2008 FFB 1 3 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10.2008 $0^{Month}$ Physician 4:47 A M William L. Rawlings, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Hospice Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**X**M 2□ F Yrs MD 215.24.4126 78 09.21.1929 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 □Yes 2 No Director FLDuval Jacksonville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14094 Canyon Falls 32224 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7. in and Mental Hygiene. 7 Is marked other than "n Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Police Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Rawlings, Sr. Dorothy Hayes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Pages 1 and 2 sufferent of Health ar ortant; if item 27 if Suzanne Rawlings, Wife 14094 Canyon Falls, Jacksonville, FL 32224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or conce. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crem. 02.12.08 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, 21. Signature of Funeral Service Licensee P.A. 8717 Green Pastures Dr. Balto., 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ASPIRATION PNEUMONIA DAUS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DEMENTIA, ADVANCES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of burial-tran Due to (or as a consequence of): Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by EMPHUSEMA 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 ☐ Yes 2 ☐ No

law requires that the death certificate be executed Box 68760, attending physician P.O. s been signed by the should be detached Division or Vital Records, cate has l s after dea... filled in by ō Hospital within 24 hours a

To the Funeral I

completely filled

72 hours after

altimore, Maryland 21215-0036

5 Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 ☐ Suicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

4 Homicide

(Check only one)

29a. Certifier

29c. License number D64395

FEBRUARY 10, 2008

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MD 6565 N CHARLES ST, SUITE 209 BALTIMORE, MO 21204

31. Date filed (Month, Day, Year) State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** larolo 1116 AM teb /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Medical Affairs Baltmore (onle If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** <sup>Year)</sup> 28,1935 268-30-5037 1√2 M 2□ F 72 Ohio Director April Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at Baltimore Middle River 1 ☐ Yes 2 XNo MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t ral", or Items 23a or 2 24 Hydraplane Drive 21220 USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced r than "natura the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Westinghouse 11th Item 27 Is marked other other traumatic event, if 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Marietta Lloyd Ζ. Rea ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Coffman /step-daughter 9300 Luray Drive Baltimore MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place)
Bayview Crematory permit. Pages Department of I Important: If Ite any Injury or o 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Baltimore MD 108 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of Funeral Service Toense Balto. Muc 22. Name and Address of Facility Name and Address of Facility 300 Mace Ave. Balto Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final non-small Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a nonsequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending | for use as as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy autops, performed? Ves 21 No this certificate or Attending Physician; director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 2 Accident (Month, Day Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: / 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

rar's Signature

10 NORTH GREENE ST BALTIMORE MD 2120

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Day **Physician** 5:30 P Inez S. Ray 2008 02 05 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 3119 Bero Road Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Hours Days 1□ M 2 🛶 F 230-28-4181 80 VA Director July 8, 1927 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State "natural", or items 23a or 28a-f show dical Examiner must be notified at Baltimore MD 1 ToleYes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21227 3119 Bero Road permit. Pages I and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a any plijury or other traumatic event, the Medical Eventages. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. Black 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) federal government specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Davis Craig Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3119 Bero Road; Baltimore, Maryland 21227 Joy E. Thomas / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Quantico National Cemetery 02/20/2008 Tringle, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KIDWE Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. been signed by the should be detached it 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b autopsy performed? Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death Check onl o e To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) €R/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient 27. Manner o Dea 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural Injury Vithin 24 hours after deaun.

To the Funeral Director: Af 1 🗌 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

3 10001 31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

ROLLINGTED SHE ZUS 516

29c. License number

29d. Date signed (Month, Day, Year)

|   | ,              | For State  | State                  | of Marylan                                  |                        | artment of rtificate of               |                            |                   |  | - /            | 2008   | 04118                           |
|---|----------------|--|------------------------|---|------------------------|---------------------------------------|----------------------------|-------------------|--|----------------|--|---------------------------------|
| 17/19   |                | Registrar  1. Decedent's Name (First, Middle,                          | Last)                  |   |                        | inoute of                             | Dealli                     |                   | 2. Date of De                          | Reg. No.       |  | 3. Time of Death                |
| Physicia  |                | LUCILLE RIGBY  |                        |   |                        |                                       |                            |                   | Month<br>Februar                       | Day            | 2008   | 546 PM                          |
| /Medic<br>Examin  |                | 4a. Facility Name (If not institution,                                 | give street and nu     | umber)                                      |                        | 4b. City, Town,                       | or Location                | of Death          | 1 E VI WON                             | 4c. C          | ounty of Deat                                    | h                               |
|   |                | Sinai Hospi  | tal                    |   |                        | Balt                                  | inor                       | e                 |  |                | N/A  |                                 |
| Funeral   |                | 5. Social Security Number  | 6. Sex<br>1 ☐ M 2 🛛 F  | 7. Age (In yrs.                             |                        | If Under 1 Yea<br>Months Days         |                            | r 24 Hrs.<br>Min. | 8. Date of Bir<br>(Month, Da<br>9-15-1 | th<br>y, Year) | 9. Birti<br>Co.                                  | hplace (State or Foreign untry) |
| Director  |                | 216-54-2914 Usual Residence of Decedent                                |                        | 58  | Yrs.                   |                                       |                            |                   | 9-15-1                                 | 949            | SOU  | TH CAROLINA                     |
| and the stand   |                | 10a. State 10b. County   |                        | 10c. City                                   | y, Town or Lo          | cation                                |                            |                   |  |                |  | 10d. Inside City Limits         |
| Mary<br>-f she<br>fied a  | ţo             | MD. N/A  |                        |   | BALTIM                 | ODE                                   |                            |                   |  |                |  | 1X Yes 2 No                     |
| r 28a   | Director       | 10e. Street and Number   |                        |   | DALLIN                 | 10f. Zip Code                         |                            |                   |  | 10g. Citize    | en of What Co                                    | untry?                          |
| 72 hours after death with the Maryland<br>"natural", or items 23a or 28a-f show<br>edical Examiner must be notified at  | a D            | 3219 WESTWOOD  | AVE.                   |   |                        | 212                                   | 216                        |                   |  | U              | ISA  |                                 |
| r dea   | Funeral        | 11. Marital Status   | 12. Was Dec<br>Armed F | cedent Ever in U. orces?                    | S. 13. V               | Was Decedent of<br>f Yes, specify Cu  | Hispanic Or<br>ban, Mexica | ngin? (Spe        | cify Yes or No<br>Rican, etc.)         | - 14           | <ol> <li>Race - Amer<br/>Black, White</li> </ol> |                                 |
| s after<br>", or ite<br>amíne   | by Fu          | 1 ☐ Never Married 2 ☐ Marrie<br>3 ☐ Widowed 4 ☐ ▼Divorced              | if Yes, G              |   |                        | 1□Yes 2√∑No                           |                            |                   |  |                | Specify: BL                                      | ACK                             |
| hour<br>tural   |                | 15. Decedent   | Year or I              | Dates:                                      | 16a, Deced             | dent's Usual Occi                     | nation                     |                   |  | 16h Kino       | d of Business/                                   | Industry                        |
| in 72<br>n "na<br>Nedic   | plet           | (Specify only highes   | t grade completed,     |   | (Give                  | kind of work done<br>OO NOT use retir | durina mos                 | st of worki       | ng                                     |                |  | ·                               |
| d with<br>giene<br>ar tha<br>the n  | Completed      | Elementary/Secondary (0-12)  | Conego                 | (1-4or 5+)                                  | SUP                    | ERVISOR                               |                            |                   |  | JOHN           | IS HOPK  | INS HOSPITAL                    |
| should be filed within 72 hours<br>nd Mental Hygiene.<br>: marked other than "natural",<br>umatic event, the Medical Exa  | Be C           | 17. Father's Name (First, Middle, L                                    | .ast)                  |   |                        |                                       | 18. Moth                   | er's Name         | (First, Middle,                        | Maiden S       | urname)  |                                 |
| arkec   | 은              |  |                        |   |                        |                                       | AL                         | ICE (             | CAMBELL                                |                |  |                                 |
| 2 sho   |                | 19a. Informant's Name/Relationsh                                       |                        |   | 1                      | g Address (Stree                      |                            |                   |  |                |  |                                 |
| 1 and<br>Tealth<br>Sm 27<br>ther t  |                | FANNIE EDWARDS   | SISTER,                |   |                        | 8 W. NOE                              | CTH AV                     |                   | ALTIMOR                                |                | ation - City or                                  |                                 |
| permit. Pages 1 and 2 should be filed within 72 ho<br>Department of Health and Mental Hygiene.<br>Important: If item 27 Is marked other than "naturany Injury or other traumatic event, the Medical once. |                | 1 ☐ Burial 2 ☐ Fremation   |                        | n State c                                   | emetery, cren          | natory or other pl                    | ' i                        |                   |  |                | ,  |                                 |
| artme<br>artme<br>ortani<br>Injury  | 1              | 4 □ Donation 5 □ Other (Sp<br>21. Signature of Funeral Service L       |                        |   |                        | RIAL PAR<br>. Name and Add            |                            | 2-16-             |  |                |  | MARYLAND                        |
| Dep<br>Imp<br>any<br>onc  |                | Hant   | ()                     | NB  | 1000                   |                                       |                            |                   |  |                |  | YLAND 21217                     |
|   |                | 23a. Part1. Ent of the disease, or on shoot, or neart failure. List of | complications that     | caused the death                            |                        |                                       |                            |                   |  |                | •  | Approximate<br>Interval Between |
| Physician   | 6 6            | Immediate a se (Final disease or condition                             | any one oddoe on       |   | Seps                   | 3/5                                   |                            |                   |  |                | 1  | Onset and Death                 |
| /Medical  |                | resulting in death)  | Due to                 | o (or as a consequ                          |                        |                                       |                            |                   |  |                |  |                                 |
| Examiner  | L              | Sequentially list conditions,  | b                      |   |                        |                                       |                            |                   |  |                |  |                                 |
| led<br>isit   | Examine        | if any, leading to immediate cause. Enter Underlying                   | Due to                 | o (or as a consequ                          | uence of):             |                                       |                            |                   |  |                |  |                                 |
| be executed<br>ician and<br>burial-transit  | xan            | that initiated events<br>resulting in death) Last                      | c<br>Due to            | o (or as a consequ                          | uence of):             |                                       |                            |                   |  | -              |  |                                 |
|   | dical E        |  | d                      |   |                        |                                       |                            |                   |  |                |  |                                 |
| 1 S   | (D) 1          |  |                        |   |                        |                                       |                            |                   |  |                |  |                                 |
| death certific<br>attending p   | an/N           | iF FEMALE:<br>23b. Was decedent pregnant                               | 23c. If yes, or        | utcome pf pregna<br>birth 2 ☐ Fetal         | ancy<br>Ideath 3□      | Ectopic pregnan                       | cv                         |                   |  | 23             | 3d. Date of deli                                 |                                 |
| e dea<br>he ath   | Physician/M    | in the past 12 months? 1 ☐ Yes 2 ☐ No                                  |                        | gnant at time of de                         |                        | Other (specify)                       | -,                         |                   |  | ļ              | Month  | Day Year                        |
| hat th<br>d by l  |                | 9 ☐ Unknown  Part II. Other significant condition                      | ns contributing to     | death but not resu                          | ulting in the ur       | nderlying cause o                     | iven in Part               |                   | 23e Did t                              | obacco use     | a contribute to                                  | the cause of death?             |
| w requires that the de<br>been signed by the<br>should be detached  | d by           | Encepha  | 1 1                    | 4   |                        | identifying databet g                 |                            |                   | 1 🗆                                    |                |  | 4                               |
| w requ  | Completed      | Chronic R  |                        |   | 1 - 2                  |                                       |                            | -                 | 24a. Was                               | an             | 24h Wara au                                      | itopsy findings available       |
| sician; The law<br>s certificate has t<br>irector, page 2 s   | duc            |  | 2 / 1                  | -11   | ilure                  | -                                     |                            |                   | auto<br>perfo                          | osy<br>ormed2~ | prior to death?                                  | completion of cause of          |
|   |                | End Stage 25. Was case referred to medical                             | Kenal F                | Lailura                                     |                        |                                       | 26 Plac                    | e of Death        | 1 Yes<br>(Check only o                 | 242 No         | 1 □ Yes  | 2 ☐ No                          |
| ysici:<br>is cer<br>direct  | To Be          | examiper?<br>1☐Yes 2☐ No   | Hospital: 1            | Inpatient 2                                 | ER/Outpatien           | t 3 DOA O                             | thar                       |                   | ne 5□Resi                              |                | □Other (Spec                                     | cifv)                           |
| ng Ph<br>fter th<br>neral   |                | 27. Manner of Death 1 ☑ Natural 5 ☑ Pending                            | 28a. Date              | e of Injury<br>onth, Day Year)              | 28b. Time of<br>Injury | 28c. Inj                              | ury at<br>ork?             | 1                 | 28d. Describe                          | how injury     | occurred   |                                 |
| tendii<br>eath.<br>or: A<br>the fu  | catic          | 2 Accident investigation in Suicide 6 Could no                         | ation                  |   |                        | M 1[                                  | Yes 2                      |                   |  |                |  |                                 |
| or At<br>ifter d<br>Direct<br>in by   | Certification: | 4 ☐ Homicide determin  | ned   26e. Plac        | ce of injury - At ho<br>ding, etc. (Specif) |                        | eet, factory, office                  |                            | 2                 | 28f. Location (<br>City or To          |                | Number or Ru                                     | ıral Route Number,              |
| spital<br>ours a<br>neral<br>filled   |                | 29a. Certifier 1 Certifying  | Physician: To th       | ne best of my kno                           | wledge, death          | occurred at the                       | time, date a               | ind place.        | and due to the                         | cause(s) a     | and manner as                                    | s stated.                       |
| To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,  | Medical        |  | Examiner: On the       |   |                        |                                       |                            |                   |  |                |  |                                 |
| To the within To the Comp   | Me             | 29b. Signature and title of certifier                                  | n·L O                  |   |                        |                                       | nse number                 |                   |  |                | signed (Monti                                    |                                 |
| V   |                | John 11  | ful                    |   |                        | 000                                   | 544                        | 82                |  | Febru          | uary   | 7,2008                          |
| 8.  |                | 30. Name and address of person v                                       |                        |   |                        | Print)                                | 4 2                        | .1                | 1.                                     | 1              | R. 11  | Mo A                            |
| Sta   | ta             | 31. Date filed (Month, Day, Year)                                      | Chinley 32.            | Registrar's Signa                           | 340<br>ture            | or wes                                | ( /) «                     | eivec             | neve i                                 | TVE            | Daiti  | 7,2008<br>mure, MD<br>21215     |
| Registra  |                | FEB 1  | 3 2008                 | Strains-                                    | S S                    | Joseph .                              |                            |                   |  |                |  | -                               |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 9, 9:47 PM M David E. Seidelson February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral**  Date of Birth (Month, Day, Year) Hours 1 M 2 □ F Months Days Min 78 Director 187-22-5282 PA 10/05/1929 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Martical Examinar most honer than 100 mo 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits 1 ☐Yes 2 No Director MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852-377 Congressional Lane United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Education Elementary/Secondary (0-12) College (1-4or 5+) Professor of Law 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Seidelson Harry Freda Marks ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis L. Seidelson/Wife 377 Congressional Lane Rockville, MD 20852-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Feb 13 Beltsville, Maryland 4 Donation 5 Dother (Specify) Chesapeake Crematory 2008 21. Signature of Funeral 22. Name and Address of Facility MU0382 Rapp Funeral & Cremation Services Stille D Tolling 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mede of dyint, such as car shock, or heart failure. List only one cause on a, ch line. or respiratory arrest, Approximate Interval Betw Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical a consequence of): Examiner ben Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to (or as a consequence of) Examine the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknowr 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 1 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Box 68760 Division or Vital Records, P.O. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, f within 24 hours a

P Certification: Medical

Manner \*

Natural 2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

NILLIAM

29b. Signature and title of certifier

Registrar

State

OOLE

30. Name and address of person who completed cay

5 Pending investigation

6 Could not be

determined

Hospital:

1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

1 ☐ Yes 2 ☐ No

KIRKE

ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

of death (Item 23a) (Type, Print) 31

Injury

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William Lawrence Schissler February 10, 2008 3:20 A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Future Care Cherrywood Baltimore Reisterstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Victober 02, 5. Social Security Number 220-09-3949 Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 96 Yrs. Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2/☐XNo Maryland Carrol1 New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or idical Examiner must be United States of America 1261 Woodland Circle 21776 within 72 hours after death Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖫 No Specify: Specify: White ģ 3.☐Widowed 4 ☐ Divorced Completed the Medical 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) 12College (1-4or 5+) Postman Government marked other Ith and Mental Hv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
William P. Schissler Be Barbara Kraft permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked c any injury or other traumatic ever ပ 19a. Informant's Name/Relationship (Type. Print( Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine C. Colliflower 1261 Woodland Circle, New Windsor, Maryland 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Woodlawn Cemetery 02/13/08 Woodlawn, Maryland 21207 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 21. Signature of Funeral Service Licensee 8728 Liberty Road, Randallstown, Maryland 21133 JO 0333 23a. 1911. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** VC /Medical Due to (or as a consequence of): **Examiner** Asthmatic Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 monthe?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 → No 3 → Probably 4 → Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 2 🗆 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1√10 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

NA--

15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. egistrar's Signature

Minko

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 8.50PM Scarpino 2008 /Medical 02 09 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Barkwex Genesis (Backwill Baltman If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9 23 5. Social Security Number Funeral (In yrs. last birthday) Birthplace (State or Foreign Country) 219-18-4270 1 □ M 200 F 84 Yrs Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Middle River Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1911 Wilson Point Road 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 9 Specify: White 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles J. Serio Irene Christ ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Martin /daughter 7610 Northwest 40 Avenue Gainsville Fla 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 2/11/08 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of h Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metas tahic luni mn KG. /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed GERD 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy certificate performed Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After it 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

0

State

Registrar

29b. Signature and title of certifier

6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

50,Te

DZ1295

4202

70wson

29d. Date signed (Month, Day, Year)

21204

2/11/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Year Month **Physician** Dominic Ernest Verille 2:20 MY 08 Februens 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 03.01.1926 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months Days **Funeral** 81 PA 219.18.8437 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Harford Havre de Grace MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21078 1407 Superior Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: W 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 No Specify: Maryland 21215-0036 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Harford County Plumbing Inspector 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Mateo Ernest Verille 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1753 Brookview Road, Baltimore, MD 21222 Sharon Parker/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02.11.08 | Beltsville, MD permit. Page Department o Important: If any Injury or Chesapeake Crem. 4 □ Donation 5 □ Other (Specify) MOLULY 22. Name and Address of Facility CAFA/Stephen D. Lohrmann, 21. Signature of Funeral Service Licenses .A. 8717 Green Pastures Dr. Balto., MD 23a. Part1. En er the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition doug so **Physician** myoconour disease or condition resulting in death) /Medical Due to (or a a consequence of). Examiner withen siet Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duc to (or as a consequence of) Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician e attending physicals as the bi Physician/Medical 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performad/ yes 2 2 No certificate has Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 TYes Certification: To this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral 28a Date of Injury 27. Manner of Death After t (Month, Day Year) Injury Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and tine of certifier AT 2438946-410 Tebruony 02, 2008 of death (Item 23a) (Type, Print) Union Memoral 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 9:30 Betty Webb February 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Gilchrist Hospice Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🔀 F 59 218-48-4208 December 4, 1948 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 1 Yes 2 No Baltimore Funeral Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or 31st Street Apt. USA 21218 East perriit. Pages 1 and 2 should be filed within 72 hours atter death w Depriment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, th. M. dical Examiner must bonce. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Baltimore, Maryland 21215-0036 Specify: Black þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walls Robert Isom Cleo ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 31ST Street Baltimore Doris Blownt Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State GIFTS Registry Fabruary 8,2008 Hanover, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 1522 Cornelley Drive Suite P. Hanover MD 21. Signature of Funeral Service Licensee MD/21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) non The Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1☐Yes 2☐No 5 Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown Det 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ens 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after dea To the Funeral Directo completely filled in by the determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

| Physici   |                     | 1 - State Registrar  1. Decedent's Name Ruth A.   |  | ast)  |   | eruncate.                                      | of Death  | 2. Date of De Month <b>Febru</b>           |                                 | 3. Time of Death 7:10 AM M   |
|---|---------------------|---|--|---|---|--|---|--|---------------------------------|--|
| /Medic  |                     |   |  | ve street and number)   |   |  | own, or Location of De                                    |  | 4c. County                      | of Death   |
| Funeral<br>Director   |                     | 5. Social Security N<br>225-20-5  | 6. <b>5551</b>   |   | ge (In yrs. last birthe<br><b>82</b> Yr | tay) If Under 1                                |   | rs. 8. Date of Bi                          |                                 | Birthplace (State or Foreign V K Ountry)   |
| show  | or                  | Usual Residence o<br>10a. State<br>MD   | f Decedent  10b. County  Montgo  | merv  | 10c. City, Town o                       | r Location Spring                              |   |  |                                 | 10d. Inside City Limits 1 ☐ Yes 2 🎛 No   |
| a or 28a-   | Direct              | 10e. Street and Nu  |  | -   |   | 10f. Zip (                                     | Code<br>905-  |  | 10g. Citizen of V               | What Country?  States  |
| Department of Peatin and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral Director | 11. Marital Status  | ried 2 Married   | 12. Was Decedent<br>Armed Forces?<br>1  Yes 2<br>If Yes, Give<br>Year or Dates: |   | 13. Was Decede<br>If Yes, specif               | ent of Hispanic Origin? fy Cuban, Mexican, Pu             | (Specify Yes or No<br>erto Rican, etc.)    | Blac                            | ce - American Indian,<br>ck, White, etc.   |
| ne.<br>han "natur<br>e Medical  | Completed           | (Special Elementary/Second  | 15. Decedent's E<br>cify only highest g<br>ondary (0-12)   | Education<br>rade completed)<br>College (1-4or                                  | 5+)                                     |  | Occupation ( done during most of we retired)  ative Assis |  | Vetera                          | usiness/Industry in's stration   |
| ental Hygie<br>ked other t  | To Be Co            | 17. Father's Name Joseph  |  | it)   | 1 114                                   |  | 18. Mother's N  | ame (First, Middle<br>Franklin             |                                 |  |
| alth and M  | -                   | 19a, Informant's N  | ame/Relationship   |   |   |  | Street and Number or ch Harbour                           |  |                                 |  |
| ant: If Item  |                     | 20a. Method of Dis<br>1 ☐ Burial 2<br>4 ☐ Donation  | ☐Cremation 3   | Removal from State  | cemetery,                               | isposition (Name<br>crematory or oth<br>Washin | her place)  | Feb 12<br>2008                             |                                 | City or Town, State  |
| Departi<br>Import<br>any inj  |                     | 21. Signature of F  | uneral Service Lic   | ensee   | ~~                                      |  | Address of Facility<br>uneral & Cre<br>st Ave. Sil        | emation Se<br>Lver Sprin                   | ervices<br>ng, Maryl            | and 20910-   |
| hysician and // Medical xaminer   | Examiner            | 23a. Part1. Enter shock, or her shock, or her immediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to incause. Enter Undic Cause (Disease or that initiated event resulting in death) | onditions, injury sinjury sinj | a. Due to (or as  b. Due to (or as  | ine.                                    | CGr W  | of dying, such as card                                    | iac or respiratory                         | •                               | Approximate<br>Interval Between<br>Onset and Death                                     |
| ate has been signed by the attending physician bage 2 should be detached for use as the buri  | Physician/Medical   | IF FEMALE:<br>23b. Was deceder<br>in the past 12<br>1 ☐ Yes 2<br>9 ☐ Unknown  | months?  | 23c. If yes, outcome 1  Live birth 4 Pregnant a                                 | 2 Fetal death                           | 3 □Ectopic pre<br>5 □ Other (spe               |   |  |                                 | ate of delivery<br>onth Day Year   |
| n signed I  | by                  | Part II. Other signi  | ficant conditions  | contributing to death b   | out not resulting in the                | ne underfying car                              | use given in Part I.                                      |  | tobacco use con<br>Yes 2 No     | tribute to the cause of death?  3 □ Probably 4 □ Unknown                               |
| cate has been si  | Completed           |   |  |   |   |  |   | 24a. Was<br>auto<br>perf<br>1∐ Yes         | opsy<br>formed?                 | Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☒ No |
| within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s  | n: To Be            | 25. Was case refe<br>examiner?<br>1 ☐ Yes 2 ☑<br>27. Manner of Dea<br>1 ☑ Natural   | (No  | Hospital: 1 Inpation  | ury 28b. Tir                            |  | 0.1   | Home 5 Res                                 |                                 |  |
| after death.  Director: Af in by the fu   | Certification:      | 2 Accident 3 Suicide 4 Homicide   | investigation  6 Could not determine   | be 28e. Place of inj  | jury - At home, farm<br>tc. (Specify)   | М  | 1 ☐ Yes 2 ☐ No  |  | (Street and Numi<br>own, State) | ber or Rural Route Number,   |
| ral   | Medical Ce          | 29a. Certifier<br>(Check only<br>one)   | 1  Certifying F<br>2  Medical Exa  | Physician: To the best<br>aminer: On the basis of<br>and manner st              | of examination and/                     | death occurred a<br>or investigation,          | at the time, date and pla<br>in my opinion, death or      | ace, and due to the<br>courred at the time | e cause(s) and m                | anner as stated.<br>and due to the cause(s)  |
| n 24 houne<br>ne Fune<br>pletely fi   |                     |   |  |   | _                                       | 29c.   | License number  |  | 29d. Date signe                 | ed (Month, Day, Year)  |
| within 24 hours after death.  To the Funeral Director; After completely filled in by the fune   |                     | •   | title of certifier   | )~  | MC                                      | )   ()   | 00624   | 35   | 2/5                             | 1/2008<br>MD 20850   |

04126

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anne. To Be Completed by Funeral Director Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner To the HospItal or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

**Physician** /Medical Examiner

**Funeral** 

| 1 - For State Registrar   | State of Maryla  |                           | tificate of  |   |  | Reg. No.                       | 0.0  | U4120  |
|---|--|---------------------------|--|---|--|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, L.   | ast)   |                           |  |   | 2. Date of De<br>Month                 | eath<br>Day                    | Year   | 3. Time of Death                                   |
| Edward James W  | hitaker  |                           |  |   | Feb.                                   |                                | 2008   | 3:54 P M   |
| 4a. Facility Name (If not institution, gi   | ve street and number)  |                           | 4b. City, Town, o  | Location of Death                         |  |                                | y of Death                                     |  |
| 16010 Falls Rd.   |  |                           | Sparks If Under 1 Year   |   | To bu (b)                              |                                | imore  |  |
| 072-30-0008   | Sex 7. Age (In yr<br>X□ M 2□ F 68  | s, last birthday)<br>Yrs. | Months Days  | If Under 24 Hrs.<br>Hours Min.            | 8. Date of Bir<br>(Month, Da<br>June 1 | ay, Year)                      | 9. Bittip<br>Cour<br>N                         | * /  |
| Usual Residence of Decedent  10a, State 10b, County   | 10c. (   | City, Town or Loc         | ation  |   |  |                                | 1  | 0d. Inside City Limits                             |
|   |  |                           |  |   |  |                                |  | 1 ∐Yes 2√∑ No                                      |
| MD Baltim  10e. Street and Number   | ore S  | parks                     | 10f. Zip Code  |   |  | 10g. Citizen of                | What Cour                                      | ntry?  |
| 16010 Falls Rd.   |  |                           | 2115   |   |  | USA                            |  |  |
| 11. Marital Status  | 12. Was Decedent Ever in<br>Armed Forces?  | U.S. 13. W                | Vas Decedent of H<br>Yes, specify Cuba   | ispanic Origin? (Sp<br>an, Mexican, Puert | pecify Yes or No<br>o Rican, etc.)     | )- 14. Ra<br>Bla               | ce - Americ<br>ick, White,                     |  |
| 1 ☐ Never Married 2 🏋 Married 3 ☐ Widowed 4 ☐ Divorced  | 1 Mayes 2 □ No<br>If Yes, Give<br>Year or Dates:   | 1                         | □Yes 21X No  | Specify:                                  |  | Speci                          | fy:  | white  |
| 15. Decedent's E<br>(Specify only highest g   | Education<br>rade completed)   | I (Give k                 | ent's Usual Occup  | during most of wor.                       | king                                   | 16b. Kind of E                 | Business/Ind                                   | dustry   |
| Elementary/Secondary (0-12)   | College (1-4or 5+)   |                           | O NOT use retired  | "   |  |                                |  |  |
| 17. Father's Name (First, Middle, Las   | 3  | Engi                      | neer   | 18. Mother's Nam                          | ne (First, Middle                      | Commun                         |  | ons  |
| _   | ·  | That to be a m            |  | Loue1                                     | ·                                      | Bake                           |  |  |
| James  19a. Informant's Name/Relationship   |  | Whitaker                  |  | and Number or Ru                          |  |                                |  | Code)  |
| Kathleen Whitake  |  | `                         | •  | d., Spar                                  |  |                                |  | •  |
| 20a. Method of Disposition  |  | . Place of Dispos         |  |   | Date                                   | 20c. Location                  | - City or To                                   | own, State   |
| 1 Donation 5 Other (Spec  | □Removal from State  ify)  Dt  | ılaney V                  | alley Me   | morial G                                  | ardens                                 | Timon                          |  |  |
| 21 Signature of Funeral Service Lice  | Claset   | Le<br>10                  | Mame and Addre<br>mmon Fun<br>W. Pado  | ss of Facility<br>eral Homo<br>nia Rd.,   | e of Dui                               | laney Va                       | alley<br>21093                                 | , Inc.   |
| 23a. P. 11. Enter the disease, or connock, or heart ailure. List onl<br>Imm-diate Cause (Final<br>diseate or condition<br>resulting in death) | mplications that caused the de<br>y one vause on each line.  a.  Due to (or as a cont          | eath. Do not ente         | er the mode of dyin  | g, such as cardiad                        | or respiratory a                       | arrest,                        |  | Approximate<br>Interval Between<br>Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last             | b. Due to (or as a consi   |                           |  |   | -                                      |                                |  |  |
|   |  |                           |  |   |  | 1                              |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?<br>1 □ Yes 2 □ No<br>9 □ Unknown   | 23c. If yes, outcome pf preg<br>1 □ Live birth 2 □ Fe<br>4 □ Pregnant at time o<br>9 □ Unknown | etal death 3 🗆            | Ectopic pregnancy<br>Other (specify)   | ,   |  |                                | ate of delive                                  | ery<br>Day Year                                    |
| Part II. Other significant conditions   | contributing to death but not re   | esulting in the un        | derlying cause giv   | en in Part I.                             |  | ,                              |  | he cause of death?                                 |
| 1   |  |                           |  |   | 940                                    | ¥es 2□ No                      | 3   Proi                                       | bably 4 ∐Unknown                                   |
|   |  |                           |  |   | 24a. Was<br>auto<br>perf<br>1□ Yes     |                                | . Were auto<br>prior to co<br>death?<br>1  Yes | opsy findings available impletion of cause of      |
| 25. Was case referred to medical  |  |                           | 1  | 26. Place of Dea                          |  | 1-                             |  |  |
| examiner?<br>1 ☐ Yes 2☐/No  | Hospital: 1 ☐ Inpatient 2  | ☐ ER/Outpatient           | 3 DOA Oth  |   | 1                                      | idence 6 ⊟O                    | ther (Speci                                    | fy)  |
| 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of              | 28c. Injui<br>Wor  |   |  | how injury occu                |  |  |
| 2 Accident investigation 3 Suicide 6 Could not 4 Homicide determine   | be 280 Blood of injury - At  | home, farm, stre<br>cify) |  | 100 25.110                                | 28f. Location (<br>City or To          | (Street and Nurr<br>wn, State) | ber or Run                                     | al Route Number,                                   |
|   | Physician: To the best of my kaminer: On the basis of exami                                    |                           |  |   |  |                                |  |  |
| 29b. Signature and title of certifier   | and manner stated.   |                           | 29c. Licens  | e number                                  |  | 29d. Date sign                 | ed (Month,                                     | Day, Year)   |
| Two Il  | you por  |                           | 125  | 0729                                      |  | -//                            | 110  | 008  |
| 30. Name and address of person who  |  |                           |  |   | 0105                                   |                                |  | 205  |
| Paul Celano, M.D.   | 6701 N. (  | Charles                   | St., Tow   | son, MD                                   | 21204                                  | West Pa                        | avili  | on, Suite  |
| 31. Date filed (Month, Day, Year)  FFB 1 3 2  | 37 Registrar's Sig   | A Agos                    | A STATE OF THE STA |   |  |                                |  |  |

State Registrar

9+

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 8, 2008 **Physician** Deborah Vanessa Whittaker 10:25am м /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospice Dove House Carrol1 Westmnster 8. Date of Birth (Month, Day, Feb 26, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Country) Days Hours Min 1 ☐ M 2 😾 F 215-58-4629 54 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Baltimore Baltmore 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7900 Dunhill Village Apt. 201 21244 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Rep. Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill ment of Health and Mental Hiant: If item 27 is marked oth Be James Whittaker Margaret Lewis 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Courtney Collins (Son) 4303 Coolidge Ct., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 TBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Johnsville Cemetery 2/13/2008 Sykesville, Home & Chapel 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Maight / Funeral once MOO) PO Box 195, Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of pach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed the burial-transit attending physician and for use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregn 3 Ectopic pregnancy in the past 12 mo Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performe certificate 2 1 No 1 Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 6 Other (Specify) this funeral To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation Vatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number of death (Item 23a) (Type, Print) enter 31. Date filed (Month, Day, 32. Registrar's Signature State 13 2008 Registrar DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            |  |                        | For State Registrar   | State of                            | Maryland                      |                    | rtificate of i                             |  | /lental Hygi<br>Reg              | ene<br>1. No. 2008              | 04128  |
|----------------------------|--|------------------------|---|-------------------------------------|-------------------------------|--------------------|--|--|----------------------------------|---------------------------------|--|
|                            | VEL U  | u                      | 1. Decedent's Name (First, Midd   | lle, Last)                          |                               |                    |  | -  | 2. Date of Death                 |                                 | 3. Time of Death                                   |
|                            | Physici<br>/Media  |                        |   | James Thoma                         | s Warr:                       | ing, J             | r.   |  | Month<br>February                | Day Year 7 8, 2008              | 7:00PM M   |
| 4                          | Examir   |                        | 4a. Facility Name (If not institution   |                                     |                               |                    |  | r Location of Death                        |                                  | 4c. County of Deatl             |  |
|                            |  |                        | Washington  | Adventist                           | Hospita                       | al                 | Tal  | koma Park                                  |                                  | Mont                            | gomery   |
|                            | Funeral  |                        | 5. Social Security Number   | 6. Sex 7.                           | Age (In yrs. la               |                    | If Under 1 Year                            | If Under 24 Hrs.<br>Hours Min.             | 8. Date of Birth<br>(Month, Day, |                                 | oplace (State or Foreign untry)                    |
|                            | Director   |                        | 578-48-6499   | 1 <b>X</b> 1 M 2□F                  | 71                            | Yrs.               | Months Days                                | Hours Min.                                 | June 4,                          |                                 | hington, D.C                                       |
|                            | pu ,   |                        | Usual Residence of Decedent   |                                     | 10- 01-                       | , Town or Lo       |  |  |                                  |                                 |  |
|                            | arylar<br>show   | _                      | 10a. State 10b. Count   | /                                   | Toc. City                     | , Town or Lo       | cation                                     |  |                                  |                                 | 10d. Inside City Limits                            |
|                            | death with the Maryland<br>ims 23a or 28a-f show<br>r must be notified at  | Director               |   | ontgomery                           |                               |                    |  | Rockville                                  |                                  |                                 | 1 □ Yes 2 No                                       |
|                            | or 2   | Dir                    | 10e. Street and Number  |                                     |                               |                    | 10f. Zip Code                              |  | 109                              | g. Citizen of What Co           | untry?   |
|                            | ath v<br>s 23a   | ra                     | 165   | 28 Emory La                         |                               |                    |  | 20853                                      |                                  |                                 | States   |
|                            | er de  | Funeral                | 11. Marital Status  | 12. Was Decede<br>Armed Force       | es?                           | 3. 13.             | Was Decedent of H<br>If Yes, specify Cuba  | ispanic Origin? (Sp<br>an, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.) | 14. Race - Amer<br>Black, White |  |
| 36                         | s afte   | by F                   | 1 ☐ Never Married 2X Ma<br>3 ☐ Widowed 4 ☐ Divorce  | If Yes, Give                        | 195                           | 9                  | 1 □ Yes 2 🖾 No                             | Specify:                                   |                                  | Specify:                        |  |
| Maryland 21215-0036        | n 72 hours after death with the Marylar<br>"natural", or items 23a or 28a-f show<br>Atleal Examiner must be notified at    |                        |   | Year or Date                        | es: 196                       | _                  | dent's Usual Occup                         | ation                                      |                                  | 6b. Kind of Business/l          | White  |
| 5                          | be filed within 72 hartal Hygiene. d other than "natuevent, the Medical  | Completed              | (Specify only high  | est grade completed)                |                               | (Give              | kind of work done of<br>DO NOT use retired | during most of work                        | king                             | bb. Kind of business/f          | nuustry  |
| 12                         | filed within<br>Hygiene.<br>other than "<br>ent, the Me  | Ĕ                      | Elementary/Secondary (0-12)   | College (1-4                        | or 5+)                        |                    |  | Lather                                     |                                  | Constr                          | uction   |
| 9                          | nould be filed v<br>I Mental Hygie<br>narked other i<br>natic event, th  | Ö                      | 17. Father's Name (First, Middle  | , Last)                             |                               |                    |  |  | e (First, Middle, Ma             |                                 |  |
| an                         | d be<br>ental<br>ced c   | o Be                   | Lama  | s Thomas Wa                         | rring                         | Sr                 |  |  | Milda                            | ed Day                          |  |
| ₹                          | should<br>and Men<br>s marke<br>umatic   | 2                      | 19a. Informant's Name/Relation  |                                     | LLLIE                         |                    | ng Address (Street                         | and Number or Rui                          |                                  | City or Town, State, Z          | in Code)   |
| Z                          | and 2 sho<br>alth and<br>27 is ma<br>er traum  |                        |   |                                     |                               |                    | ,  |  | · ·                              | Maryland                        | ,,   |
| Ó                          | ## <del>#</del> # #  |                        | Kay F. Warri  | ng/_wire                            | 20b. Pl                       | ace of Dien        | eition /Name of                            |  |                                  | Oc. Location - City or          |  |
| Baltimore,                 | Pages<br>ment of I<br>ant: If Ite<br>ury or o  |                        | 1 ☐ Burial 2 【X Cremation   |                                     | ate C6                        | metery, cre<br>Mon | natory or other place                      | <sup>e)</sup> Febi                         | ruary                            |                                 |  |
| 華                          |  |                        | 4 □ Donation 5 □ Other (  |                                     | C                             | remate             | orium Inc                                  | . 16,                                      | 2008  <br>ert A. Pi              | Bethesda,                       | Maryland   |
| Ba                         | permit. Depart Import any inj once.  |                        | 21. digitature of Funeral Service   | 7//                                 | 14004                         | Be                 | thesda-Cl                                  | nevy Chas                                  | e Inc                            | 557 Wisco                       | neral Home/<br>nsin Avenue                         |
|                            |  |                        | 23a. Part1. Enter the disease of shock, or heart failure. Lis   | or complications that cau           | NUU.                          | Do not en          | erthe mode of dvin                         | narytand                                   | or respiratory arres             | t t                             | Annroximate  |
|                            |  |                        | shock, or heart failure. Lis<br>Immediate Cause (Final  | t only one cause on eac             | h line.                       | 11                 | 1  | ig, odori do odraido                       |                                  |                                 | Approximate<br>Interval Between<br>Onset and Death |
|                            | Physician /Medicai   |                        | disease or condition resulting in death)  | a. HCU                              | te 1                          | Viyor              | CARRI                                      | AL I                                       | NFARC                            | tion                            | 12 hours   |
|                            | Examiner   |                        |   | Due to (or                          | as a consequ                  | ence of):          |  |  |                                  |                                 |  |
| ١,                         |  | -                      | Sequentially list conditions,   | b. Due to for                       | as a suhsuqu                  | eneu ut.:          |  |  |                                  |                                 |  |
| ,x                         | rted<br>nsit   | Examiner               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | <                                   |                               | ,                  |  |  |                                  |                                 |  |
|                            | be ex <b>e</b> cuted<br>ician and<br>burial-transit  | Xal                    | resulting in death) Last  | C<br>Due to (or                     | as a consequ                  | ence of):          |  |  |                                  |                                 |  |
| 260                        | icate be executed<br>physician and<br>s the burial-transit   |                        |   | d                                   |                               |                    |  |  |                                  |                                 |  |
| 68760,                     | tificate t<br>ig physi<br>as the t   | edical                 |   | u                                   |                               |                    |  |  |                                  |                                 |  |
| Box                        |  | 2                      | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outco                  | me pf <u>pr</u> egnar         |                    |  |  |                                  | 23d. Date of deli               | verv   |
| ă                          | requires that the death cer<br>sen signed by the attendin<br>rould be detached for use                                     | by Physician/M         | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  |                                     | n 2 ☐ Fetal<br>tat time of de |                    | Ectopic pregnancy Other (specify)          |  |                                  | Month                           | Day Year   |
| P.0.                       | w requires that the de<br>been signed by the<br>should be detached   | Jysi                   | 9 Unknown   | 9□Unknow                            | n                             |                    |  |  |                                  |                                 |  |
|                            | that<br>ned b  | y P                    | Part II. Other significant condit   | ions contributing to deat           | h but not resul               | lting in the u     | nderlying cause give                       | en in Part I.                              | 23e. Did toba                    | cco use contribute to           | the cause of death?                                |
| rds                        | quires   | Q<br>Q                 |   |                                     |                               |                    |  |  | 1 ☐ Yes                          | 2 □ No 3 □ Pro                  | obably 4 Unknown                                   |
| 00                         | > 0 5  | Completed              |   |                                     |                               |                    |  |  | 24a. Was an                      | 24b. Were au                    | topsy findings available                           |
| Re                         | The lav  | 티                      |   |                                     |                               |                    |  |  | autopsy<br>performe<br>1∐ Yes 2  | prior to c                      | ompletion of cause of                              |
| a                          | ilclan: Th<br>certificate<br>rector, pag   |                        | 25. Was case referred to medical  | al .                                |                               |                    |  | 00 81 / 6 / 1                              |                                  | •                               | 2 □ No   |
| Division or Vital Records, | Physician:<br>this certificaral director, p  | Be                     | examiner?   | Hospital:                           | atient 2 □ E                  | R/Outpatier        | nt 3 DOA Othe                              | Or:  | th (Check only one)              |                                 |  |
| 0                          |  | <u>و</u>               | 27. Manner of Death   | 28a. Date of                        | njury                         | 28b. Time o        |  |  | 28d. Describe how                | ce 6 Other (Spec                | city)  |
| on                         | Attending Phirdeath. ector: After thi  | tio                    | 1 Natural 5 Pendi<br>2 Accident invest  | ng (Month,<br>igation               | Day Year)                     | Injury             | f 28c. Injur<br>Worl<br>M 1 □              | k?<br>Yes 2 ☐ No                           |                                  |                                 |  |
| is:                        | I or Attend<br>after death.<br>Director: /   | lica                   | 3 Suicide 6 Could   | not be 28e. Place of                |                               |                    | eet, factory, office                       |  | 28f. Location (Stre              | et and Number or Ru             | ral Route Number.                                  |
| <u>S</u>                   | after<br>Dire  | erti                   | 4 ☐ Homicide determ   | building                            | , etc. (Specify,              | )                  |  |  | City or Town,                    | State)                          |  |
|                            | spita<br>ours<br>neral   | 2                      | 29a. Certifier 1 Certifyl   | ng Physiclan: To the be             | est of my know                | /ledge, deat       | n occurred at the tir                      | ne, date and place,                        | and due to the cau               | ise(s) and manner as            | stated.  |
|                            | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu | Medical Certification: | (Check only 2 ☐ Medica one)   | Examiner: On the basi<br>and manner | s of examinati                | on and/or in       | vestigation, in my o                       | pinion, death occur                        | rred at the time, dat            | e and place, and due            | to the cause(s)                                    |
|                            | Fo th<br>Within<br>Fo th   | Me                     | 29b. Signature and title of certific  |                                     |                               |                    | 29c. License                               | e number                                   | 290                              | I. Date signed (Month           | n, Day, Year)                                      |
|                            | ,- ,- F 0  |                        | (5/)  | O mi                                |                               |                    | Dal  | 6443                                       | F                                | 6000000                         | 10 2008  |
|                            | .nxl   | ŀ                      | 30. Mame and address of person  | who completed cause                 | of death (Item                | 23a) (Tyne         | Print)                                     | -117                                       | 11-6                             | DRUMLY,                         | 10,4000  |
|                            | 10   |                        | Encapry 14.   | Fisher                              | 150                           | 35 5               | had long                                   | W RED                                      | Rockville                        | Mapula                          | Nd   |
|                            | Sta  | te                     | 31. Date fied (Month, Day, Year   | ) 32. Reg                           | istrar's Signat               | ure /              | May Cit                                    | re react                                   | 1001-01110                       | 1 Mich 1919                     | -  |
|                            | Registr  |                        | FFR 1 3   | 2008                                | es st                         | A SOL              | West of                                    |  |                                  |                                 | n, Day, Year) 10, 7008.                            |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:10p M FEBRUARY 4, 2008 EUGENE E. WARD /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE JOSEPH RITCHIE HOSPICE 8. Date of Birth (Month, Day, Year) 3-29-1914 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sev 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min. 1⊠M 2□F MARYLAND 93 Director 219-03-7673 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ms 23a or 28a-f show 1.☐Yes 2☐No Director BALTIMORE MD. N/A 10g. Citizen of What Country? 10e Street and Number USA 1006 ALEXANDER AVE. 21228 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? r than "natural", or items the Medical Examiner mu 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2X Married Specify: BLACK 1 ☐ Yes 2 🗓 No 3altimore, Maryland 21215-0036 Specify þ 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CLASSIFICATION SUPERVISOR CORRECTIONS -12--8-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PINKIE HOLMES PETER B. WARD ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1006 ALEXANDER AVE. BALTIMORE, MARYLAND 21228 CONSTANCE WARD (WIFE) of Health a other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Ę, Department of Important: If it any Injury or o 1 □kBurial 2 Ø Cremation 3 □Removal from State MEADOWRIDGE MEMORIAL PARK 2-9-2008 ELKRIDGE, MARYLAND 4 □Donation / 5 Other (Specify) HIBNER Name and Address of Facility 21. Signature of Funeral Service Licensee PHILLIPS FUNERAL HOME, P.A. Work 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Panil. Errier the disease, or complications that caused the de th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Pause (Final disease or condition Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transi Due to (or as a consequence of): División or Vital Records, P.O. Box 68760, for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of dea contributing to death but pot resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 3 Probably 1 ☐ Yes 2∏ No Were autopsy findings available prior to completion of cause of 24a. Was an performe 2□ No Yes 1□ Yes 25. Was case referred medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 6 Cother (Specify) 1 Tes 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Man r of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could no re after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 9 filled in 24 hours a e Funeral I Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

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State Registrar 31. Date filed (Mont

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2:50 P M Vadim Abramzon 26, 2008 January 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Suburban Hospital Bethesda Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 ☑ M 2 ☐ F 217-33-4676 75 May 6, 1932 Ukraine Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1X Yes 2 □ No Montgomery North Bethesda 10g. Citizen of What Country? 10e. Street and Number 5801 Nicholson Lane, Apt. 323 20852 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Copy Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Abramzon Yacuma Breznitskaya 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gregory Abramson-Son 9215 Quintana Drive Bethesda, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 1/27/08 Parklawn Memorial Park Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, 21. Signature of Funeral Service Licenses 1170 Rockville Pike Rockville, MD\_20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 Years Multiple Meloma disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate and the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 X Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

a or 28a-f show be notified at

items 23a

natural", or

er than "natura", the Medical E

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygir Important: If item 27 is marked other any Injury or other traumatic event, <u>tr</u>

Examiner must

Director

Funeral

þ

Completed

Be ပ MD

with the Maryland

filed within 72 hours after death Hygiene.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar as use ed by the a has certificate this within 24 hours after use...

To the Funeral Director: After this

1726108 MSC

P.O. Box 68760,

or Vital Records,

Division

LANITAL

Abeauzou

| Examin           |
|------------------|
| hysician/Medical |
| J Y              |
| ompleted I       |

P

Certification:

Medical

29a. Certifier

(Check only one)

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

Sepsis Neutropenia

24a. Was an autopsy performed 1∐ Yes 21√2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2X No

| 1 ☐ Yes 2 📉 No                | 1                            | Hospital: 1X Inpatient 2                             | ] ER/Outpatient        | 3 🗆 [    | DOA Other: 4            | I ☐ Nursing H | lome 5 ☐ Residence 6 ☐ Other (Specify)  |
|-------------------------------|------------------------------|--|------------------------|----------|-------------------------|---------------|---|
| 2 Accident                    | 5 □ Pending investigation    |  | 28b. Time of<br>Injury | М        | 28c. Injury at<br>Work? | 2 □ No        | 28d. Describe how injury occurred   |
| 3 ☐ Suicide 6<br>4 ☐ Homicide | 6 Could not be<br>determined | 28e. Place of injury - At h<br>building, etc. (Speci | nome, farm, stree      | t, facto | ory, office             |               | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |

determined 4 Homicide

JAN

3 0

25. Was case referred to medical

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier Doelle

D59244

January 27, 2008

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4416 East West Highway, Suite 410 Bethesda, MD 20814 Giselle Mery, MD 31. Date filed (Month, Day, Year)

State Registrar

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death RegistrarAMEND#10coerFH1/29/08, BMW, McCo Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Jack ALTERMAN /Medical 25 2008 7:30 A January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Rebecca Nursing Facility Potomac Montgomery Social Security Number If Under 24 Hrs. (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 Birthplace (State or Foreign Country) **Funeral** Days 1**∑** M 2□ F Director 578-38-1042 90 Sept. 11, 1917 New York Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits show a or 28a-f show be notified at 1 ☐ Yes 2 🙀 No Directo Chevy Chase Maryland

10e. Street and Number Montgomery Pether 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with Innent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or inty or other traumatic event, the Medical Examiner must be not yen or other traumatic event, the Medical Examiner must be not or the traumatic event. 4620 N. Park Avenue #1004 E Funeral 20815 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 → Yes 2 □ No 1942 –
If Yes, Give
Year or Dates: 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Bureau of Elementary/Secondary (0-12) College (1-4or 5+) Economist Labor Statistics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Alterman Frieda Spitzer P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and:
Department of Health
Important: if item 27
any injury or other tr.
once. 4620 Park Avenue #1004 E, Chevy Chase, MD Toby Alterman, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Judean Memorial Gardens 01/27/08 Olney, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Alzheimer's Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any the description of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 YJUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has be rector, page 2 s 24a. Was an autopsy 2**√** № 1□ Yes tal or Attending Phystclan: Ts after death.

I Director: After this certificated in by the funeral director, pa Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 km Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide To the Hospitai within 24 hours a To the Funeral I 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and time of certifier 29d. Date signed (Month, Day Year) D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fisher, M.D., 5530 Wisconsin Ave., #730, Chevy Chase, MD 20815 32. gistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JAN 29

2003

MARKET.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008

Months

Inverness

10f. Zip Code

7. Age (In yrs. last birthday)

10c. City, Town or Location

69

4b. City, Town, or Location of Death

Hours

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Min.

Annapolis If Under 1 Year | If Under 24 Hrs.

Days

34453

3. Time of Death

11:43 PM

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 No

Pennsylvania

January

8. Date of Birth (Month, Day, Yo 9/6/1938

4c. County of Death

10g. Citizen of What Country?

14. Race - American Indian,

Black, White, etc.

USA

Anne Arundel

**Physician** /Medical Examiner

1 - For State Registrar

10a. State

Florida

11. Marital Status

10e. Street and Number

Director

5. Social Security Number

183-30-9616

Usual Residence of Decedent

William B. Ahlers, Jr.

10b. County

3141 N. Hooty Point

Citrus

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

6. Sex 1 M M 2 □ F

**Funeral** 

Director "natural", or items 23a or 28a-f show edical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Rem 27 is marked other than "natural", or items 23a or 2 may hjury or other traumatic event, the Medical Examiner must be none. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1957-61 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White ρ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Commercial Fisherman Fishing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William B. Ahlers, Sr. Grace Weaver ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21403 Ruth A. Day/ Sister 680 Fairview Ave., Annapolis, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify)

21. Signator | Funeral Secret Receive Kalas Crematory 1-29-08 Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** - Wiphysema Years /Medical Due to (or as a con equence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit physician and sthe burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of coxtifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Txpe, Print) Parkway, annapolo, More STERIO BETH, our 2001 Medical Parkway, annapolo, Mo STERIO BETH, OUD

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

**JAN 29** 

2008

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 50 P M **Physician** Month /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annal Ame Ann Center 00/15 Year I f Under 24 Hrs. 5. Social Security Number If Unde 8. Date of Birth (Month, Day, Year) 11/04/1939 9. Birthplace (State or Foreign Sex 14⊡M 2□F 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours 212-38-4145 68 Director Iowa Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Millsboro Directo Delaware Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27159 Indian Meadow Circle 19966 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Wes 2 ☐ No If Yes, Give Year or Dates: 1956–62 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 I.B.E.W. Union Steam Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George K. Antellas Mary Lambert 27 Is marked traumatic e 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health ar Important: If item 27 is Connie L. Antellas/Wife 27159 Indian Meadow Circle, Millsboro, DE 19966 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Culpeper National Cemetery 01/29/2008 Culpeper, Virginia of Fune al Septice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Mlle 2973 Solomons Island Rd., Edgewater, MD 21037 rant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HodaKin's disease or condition resulting in death) Cas /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 No Completed certificate has been rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performe 2 **X**No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident death within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 12008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syle 300 Annapolis 900

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year

ar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|             |  |                | 1 _ State   | State of Maryland   |                                       | artment of F<br><i>tificate of</i>                |  |   | 7008  | 04135  |
|-------------|--|----------------|---|---|---------------------------------------|---|--|---|---|--|
| 5           | Dhamisi  |                | Registrar  1. Decedent's Name (First, Middle, Last)   |   |                                       | inouto or   | Boain  | 2. Date of Dea                          |   | 3. Time of Death                                   |
| No.         | Physici<br>/Medic  |                | Robert Carrol   |   |                                       |   |  | Februar                                 | ry 8 2008   | 9:00A <sup>M</sup>                                 |
|             | Examin<br>Funeral<br>Director  | er             | 214-28-0621   | reet and number)  7. Age (In yrs. la  | ast birthday)<br>Yrs.                 | Unic  | on Bridge If Under 24 Hrs. Hours Min.                  |   | y, Year) Coi                                      | nplace (State or Foreign<br>untry)<br>'Yland       |
|             | and  |                | Usual Residence of Decedent  10a. State 10b. County   | 10c. City   | Town or Lo                            | cation  |  |   |   | 10d. Inside City Limits                            |
|             | Maryl<br>I-f sho<br>fied at  | tor            | Maryland Carroll  |   | Ur                                    | nion Brid   | lge  |   |   | 1 X Yes 2 ☐ No                                     |
|             | ith the  | Director       | 10e. Street and Number  |   |                                       | 10f. Zip Code                                     |  |   | 10g. Citizen of What Co                           | untry?   |
|             | eath w<br>ns 23a<br>must I   | Funeral        | 42 S. Main St.  | 2. Was Decedent Ever in U.S   | 13. \                                 | Was Decedent of H                                 | 21791<br>Iispanic Origin? (Sr                          | necify Yes or No                        | U.S.A   |  |
| 036         | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | þ              | 1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced   | Armed Forces?  1 X Yes 2 □ No If Yes, Give Year or Dates: 1953-                                       |                                       | f Yes, specify Cub<br>1 ☐ Yes 2 🔀 No              | lispanic Origin? (Sj<br>an, Mexican, Puert<br>Specify: | o Rican, etc.)                          | Black, White                                      |  |
| 21215-0036  | n 72 ho<br>"natur<br>edical  | Completed      | 15. Decedent's Educa<br>(Specify only highest grade   | ation<br>completed)   | 16a. Deced                            | lent's Usual Occup                                | nation<br>during most of word<br>d)                    | king                                    | 16b. Kind of Business/I                           | ndustry  |
| 7121        | within jene.   | dmo            | Elementary/Secondary (0-12)   | College (1-4or 5+)  |                                       |   | ment ope   |   | cement o  | co.  |
|             | 2 should be filed<br>and Mental Hygi<br>Is marked other<br>aumatic event, ti   | BeC            | 17. Father's Name (First, Middle, Last)   |   |                                       |   | 18. Mother's Nam                                       | ne (First, Middle,                      | Maiden Surname)                                   |  |
| Maryland    | should be and Mental smarked or umatic eve   | ြို            | Elmer Crouse Bohn   | Drink   | 10h Mailin                            | . Addus a (Chuan                                  |  | a Louise                                | · · · · · · · · · · · · · · · · · · ·             | (Co.d.)  |
|             | nd 2 sh<br>lith and<br>27 Is n<br>r traun  |                | 19a. Informant's Name/Relationship (Type<br>Mary Deborah Engle/   |   |                                       | <sub>ig Address (<i>Street</i><br/>Franklin</sub> |  |   | er, City or Town, State, Z<br>er, MD 2115         |  |
| altimore,   | es 1 and 2<br>of Health<br>fitem 27 I  |                | 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Re  | 20b. Pla  |                                       | sition (Name of natory or other place             |  | Date                                    | 20c. Location - City or                           | <u> </u>   |
| ţ           | t. Pag<br>rtment<br>tant: I  | -              | 4 ☐ Donation 5 ☐ Other (Specify)  | A11   |                                       |   | ion 2/12   |   | Sykesville,                                       |  |
| Ba          | permit. Pages 1 an<br>Department of Heal<br>Important: If item 2<br>any Injury or other<br>once.   | 1              | 21. Signally e of Funeral Service License   | Darller   | (                                     | E. Broa   | idway Ui   | nion Bri                                | uneral Home<br>dge, MD 217                        | 791  |
| ngr         | Physician  |                | 23a. Part1. Enter the disease, or complic<br>shock, or heart failure. List only one<br>Immediate Cause (Final | cause on each line.   |                                       | ARCI N  |  | or respiratory ai                       | rest,   | Approximate<br>Interval Between<br>Onset and Death |
|             | /Medical   |                | disease or condition resulting in death)  | Due to (or as a consequ   |                                       | 7,100115  |  |   |   | 994 2000   |
| 4.          | Examiner   | <u>-</u>       | Sequentially list conditions, if any, leading to immediate  | Due to (or as a consequ   | ence of):                             |   |  |   |   |  |
| V           | outed<br>Id<br>ansit   | Examiner       | Cause (Disease or injury that initiated events  |   |                                       |   |  |   |   |  |
| . 60        | icate be executed<br>physician and<br>s the burial-transit   | EX             | resulting in death) Last  | Due to (or as a consequent  | ence of):                             |   |  |   |   |  |
| 68760,      |  | edical         | d.  |   |                                       |   |  |   |   |  |
| P.O. Box    | The law requires that the death certificate has been signed by the attending page 2 should be detached for use as in   | Physician/M    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                       | c. If yes, outcome pf pregnar<br>1 □Live birth 2 □ Fetal<br>4 □ Pregnant at time of de<br>9 □ Unknown | death 3□                              | Ectopic pregnanc<br>Other (specify)               | у  |   | 23d. Date of deli<br>Month                        | very<br>Day Year                                   |
| ď.          | ires that the de<br>signed by the a<br>be detached f   | by Ph          | Part II. Other significant conditions conti   | buting to death but not resul   | ting in the ur                        | nderlying cause giv                               | ren in Part I.   | 23e. Did to                             | obacco use contribute to                          | the cause of death?                                |
| ords        | w require:<br>been sig<br>should be  |                |   |   |                                       |   |  | 10                                      | res 2⊡No 3□Pr                                     | obably 4 □Unknown                                  |
| Il Records, | The law rate has be page 2 sh  | Completed      |   |   | ·                                     |   |  |   | an 24b. Were au prior to control death? 1 Yes     | topsy findings available completion of cause of    |
| Vita        | nysician: Thatis certificate director, pag   | Be             | 25. Was case referred to medical examiner?  | spital:   | :n/o. +/                              | t all DOA Oth                                     | 26. Place of Dea                                       | 1                                       |   |  |
| Division or | ding Phys<br>n.<br>After this<br>funeral di  | on: To         | 27. Mann of Death  1 Natural 5 Pending  | I □ Inpatient 2 □ E   | R/Outpatien<br>28b. Time of<br>Injury | 1 3LI DOM   | 4 🗆 Nursing H  |   | dence 6 Other (Spec<br>now injury occurred        | cify)  |
| /isio       | or Attendi<br>nfter death.<br>Director: A<br>in by the fu  | Certification: | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be   | 28e. Place of injury - At hor   | ne, farm, stre                        |   | Yes 2 □ No   | 28f. Location (S                        | Street and Number or Ru                           | ral Route Number,                                  |
| á           | tal or rs after al Dire  | Certi          | 4 Homicide determined   | building, etc. (Specify,  | )                                     |   |  | City or Tov                             | vn, State)  |  |
|             | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director; p  | Medical        | (Check only 2   Medical Examine one)  | cian: To the best of my know<br>er: On the basis of examinati<br>and manner stated.                   | rledge, death<br>on and/or in         | occurred at the ti<br>vestigation, in my          | me, date and place<br>opinion, death occu              | e, and due to the<br>urred at the time, | cause(s) and manner as<br>date and place, and due | stated. to the cause(s)                            |
|             | vith<br>To   | 2              | 29b. Signature and title of certifier   | to My   |                                       | 29c. Licens                                       | 5 39 Z   |   | 29d. Date signed (Mont)                           | n, Day, Year)                                      |
|             | 10   |                | 30. Name and address of person who com  | and the car are   | 23a) (Type,                           | Print)  | w I lan  | Jariel -                                | -MD21157  |  |
|             | Sta  | te             | 31. Date filed (Month, Day, Year)   | 3 Registrar's Signat  | ure                                   | 11871   | ettub  | DIVIDUR                                 | L KIDOLID /                                       |  |
|             | Registr  |                | FFR 1 3 2008  | Bear A  |                                       |   |  |   |   |  |

Registrar
DHMH 17 Rev 1/2001

State

ORIGINAL

615 West Montgomery Ave. Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registrar's Signature

Dr. Douglas R. Shumaker M.D.

**JAN 30** 

31. Date filed (Month, Day, Year)

|            |   |                | for State Registrar   | te or maryiand                                     |                        | tificate of t                           |   | мептат нуд<br>в  | leg. No. 200               | 8 04137  |
|------------|---|----------------|---|--|------------------------|---|---|--|----------------------------|--|
| -100       | Physici   | an             | Decedent's Name (First, Middle, Last)   |  |                        |   |   | 2. Date of Dea<br>Month  | Day Year                   | 3. Time of Death                                 |
|            | /Medic  | al             | Sirvardi Bazoians   |  |                        | 4h Cihi Tourn o                         | r Location of Death                         | January  | 23, 2008                   | 8:05 PM  |
|            | Examin  | er             | 4a. Facility Name (If not institution, give street a Clayton Comfort Care   | na number)   |                        | Silver                                  |   |  | Montgo                     |  |
|            | Funeral   |                | Social Security Number 6. Sex   | 7. Age (In yrs. la                                 | st birthday)           | If Under 1 Year<br>Months Days          |   | 8. Date of Birth   |                            | irthplace (State or Foreign<br>Country) Republic |
|            | Director  |                | None 1 M 2  | XJ F   | 83 Yrs.                | WOTHIS Days                             | Hours Will.                                 | Nov. 26  |                            | Georgia  |
|            | and<br>ww   |                | Usual Residence of Decedent  10a. State 10b. County   | 10c. City,   | Town or Loc            | eation                                  |   |  |                            | 10d. Inside City Limits                          |
|            | Maryl<br>-f sho<br>ied a  | tor            | Maryland Montgomery   |  | Rocky                  | ille                                    |   |  |                            | 1 X Yes 2 No                                     |
|            | or 28a  | Directo        | 10e. Street and Number  |  |                        | 10f. Zip Code                           |   | 1  | l0g. Citizen of What (     | Country?   |
|            | 23a c   |                | 11302 Ashley Drive  |  |                        | 208                                     |   |  | lepublic o                 |  |
|            | er de   | Funeral        | Arr   | s Decedent Ever in U.S<br>ned Forces?<br>]Yes 2⊠No | i. 13, V               | Vas Decedent of H<br>Yes, specify Cuba  | lispanic Origin? (Sp<br>an, Mexican, Puerti | pecify Yes or No-<br>p Rican, etc.)  | 14. Race - An<br>Black, Wh | nerican Indian,<br>nite, etc.                    |
| 35         | be filed within 72 hours after death with the Maryland ttal Hyglene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at | þ              | _ If Y  | es, Give<br>ar or Dates:                           | 1                      | ☐ Yes 2█ No                             | Specify:                                    |  | Specify: Ca                | aucasian   |
| 5-0036     | 72 hou<br>natura<br>lical E   | Completed      | 15. Decedent's Education<br>(Specify only highest grade comp  | leted)   | 16a. Deced             | ent's Usual Occup                       | ation                                       | kina   | 16b. Kind of Busines       | s/Industry                                       |
| 7          | l be filed within 72 h<br>ntal Hygiene.<br>ed other than "natu<br>event, the Medical  | mple           |   | lege (1-4or 5+)                                    |                        |   | during most of wor.                         | in in it is a second of the interest of the in | Textil                     |  |
| N          | filed w<br>Hygie<br>ther ti   | S              | 17. Father's Name (First, Middle, Last)   | 4  | Eng                    | gineer                                  | 18. Mother's Nam                            | ne (First, Middle,   | Maiden Surname)            | e  |
| yland      |   | To Be          | Gevork Bazoyan  |  |                        |   | Flora                                       | Unknown  | ,                          |  |
| Mary       | s 1 and 2 should be<br>f Health and Menta<br>Item 27 Is marked<br>other traumatic ev  | -              | 19a. Informant's Name/Relationship (Type. Pri   | nt)  | 19b. Mailin            | g Address (Street                       |   |  | r, City or Town, State     | , Zip Code)                                      |
|            | is 1 and 2<br>of Health<br>iftem 27 I   |                | Medea Ruhadze / Cous  |  |                        |   |   |  | Maryland                   |  |
| 0          | ges 1<br>t of H<br>if Iter<br>or oth  |                | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remove  | mom State  |                        | sition (Name of<br>natory or other plac |   | Date   | 20c. Location - City of    | or Town, State                                   |
| Baitimore, | permit. Pages Department of I Important: If Ite any Injury or ot once.  |                | 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee   | Ft.  |                        |   | tory 2/1/                                   |  |                            | , Maryland                                       |
| ă          | Depart Impo   |                | 21. Signature of the later to be vice Electrises  |  |                        |   |   |  | Cremation<br>11e, MD 20    |  |
|            | - A   |                | 23a. Part1. Enter the disease, or complications shock, of heart failure. List only one caus                                       | s that caused the death.<br>se on each line.       |                        |   |   |  |                            | Approximate<br>Interval Between                  |
|            | Physician   |                | Immediate Chie (Fin disease or condition  | erebral Vas  |                        |   |   |  |                            | Onset and Death  1 hour                          |
|            | /Medical<br>Examiner  |                | resulting in death)   | due to (or as a conseque                           | ence of):              |   |   |  |                            |  |
| Ė          |   | er             | Sequentially list conditions, if any, leading to immediate  | ue to (or as a conseque                            | ence of):              |   |   |  |                            |  |
|            | cuted<br>nd<br>ransit   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |  |                        |   |   |  |                            |  |
| Š,         | e exe<br>ian ar<br>urial-t  | I Ex           | resulting in death) Last  | ue to (or as a conseque                            | ence of):              |   |   |  |                            |  |
| 09/99      | tificate be executed<br>g physician and<br>as the burial-transit  | edical         | d   |  |                        |   |   | <del>.</del>   |                            |  |
| XOD        |   | n/Me           | IF FEMALE: 23c. If y  | es, outcome pf pregnar                             |                        |   |   |  | 23d. Date of d             | lelivery   |
| ă          | death cer<br>e attendir<br>ed for use   | Physician/M    | in the past 12 months?  | Live birth 2 Fetal                                 |                        | Ectopic pregnancy<br>Other (specify)    | /   |  | Month                      | Day Year   |
| т<br>Э     | at the<br>I by th<br>stache   | Phys           | 9 LI Unknown  | ]Unknown   |                        |   |   |  |                            |  |
| JS,        | requires that the<br>een signed by th<br>nould be detache   | by             | Part II. Other significant conditions contribution  Hypertension  | ig to death but not resul                          | ting in the ur         | iderlying cause giv                     | en in Part I.                               |  |                            | to the cause of death?  Probably 4 🖸 Unknown     |
| ecoras     |   | eted           |   |  |                        |   |   | 24a. Was a   |                            |  |
| Ŭ          | sician: The law certificate has b irector, page 2 st  | Completed      | Hyperlipidemia  |  |                        |   |   | autop:<br>perfor   | sy prior t<br>med? death   |  |
| VITAI      | lan: Trificat<br>rtificat   | Be C           | Dementia  25. Was case referred to medical  |  |                        |   | 26. Place of Dea                            | 1□ Yes<br>th (Check only or  | ne)                        | es 2 No  |
| 0 0        | Physician:<br>this certific<br>ral director,  | To E           | examiner?<br>1 ☐ Yes 2 ☑ No Hospita   | 1   Inpatient 2   E                                | R/Outpatien            |   |   | ome 5□Resid  | ence 6 🖸 Other (Sp         | Assisted<br>Decify)Living                        |
|            | Ing P   | ion:           | 1 ☑ Natural 5 ☐ Pending   | Date of Injury (Month, Day Year)                   | 28b. Time of<br>Injury | 28c. Injur<br>Wor<br>M 1 □              | yat<br>k?<br>Yes 2 ∐ No                     | 28d. Describe h  | ow injury occurred         |  |
| DIVISION   | Attenc<br>death<br>ctor:<br>y the   | ficat          | 2 Accident investigation 3 Suicide 6 Could not be determined 28e  | Place of injury - At hon                           | ne, farm, stre         |   | res ZLINO                                   | 28f, Location (S   | treet and Number or        | Rural Route Number,                              |
| 2          | al or /<br>s after<br>al Dire   | Certification: | 4 ☐ Homicide determined   | building, etc. (Specify)                           |                        |   | 1   | City or Tow  | n, State)                  |  |
|            | he Hospital or Attending Physic<br>n 24 hours after death.<br>he Funeral Director: After this or<br>pietely filled in by the funeral dire                               | edical (       | 29a. Certifier 1½ Certifying Physician: 2 ☐ Medical Examiner: O   | To the best of my known the basis of examinati     | ledge, death           | occurred at the tir                     | me, date and place                          | e, and due to the o  | cause(s) and manner        | as stated.<br>lue to the cause(s)                |
|            | = = = =   | Medi           | one) ar<br>29b. Signatur and ttele of certifier   | d manner stated.                                   |                        | _ 29c. Licens                           |   |  | 29d. Date signed (Mo       |  |
|            | vitl<br>To  | -              | Illen t   | ulles  | -me                    | De                                      | 5476  | 19   | 1/24                       | 12003  |
|            | d.  |                | 30. Name and address of person who complete   | d cause of death (tem                              | 23a) (Type, I          | Print)                                  | .01   |  | 101                        | 10000  |
|            |   |                | Allen Keilly  | mD 801   | T0/1                   | House                                   | 1/Ke /                                      | Freder   | ick M                      | U  |
| 7          | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year) / JAN 3 0 2008  | 32 Registrar's Signati                             | LITE COM               | all I                                   |   |  |                            |  |

3. Time of Death

Physicia // Ex

1 - For State Registrar

Fun Dire

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Physic /Med Exam

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division or Vital Records, P.O. Box 68760,

| sician<br>edical   | Abraham  | BRUMBERG   |   | January   | 28°, 2008°                                | 8:30 A. M  |  |  |  |  |  |  |
|--|--|--|---|---|---|--|--|--|--|--|--|--|
| miner  | 4a. Facility Name (If not institution, give street and r. 3414 Bradley Lane  | umber)   | 4b. City, Town, or Location of Death<br>Chevy Chase   |   | 4c. County of Deat<br>Montgome            |  |  |  |  |  |  |  |
| ral<br>tor   | 5. Social Security Number 109-24-9016 1.X M 2□ F   | 7. Age (In yrs. last birthday)<br>81 Yrs.  | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.  | 8. Date of Birth<br>Nov. 73                           | 1926 Te P                                 | hplace (State or Foreign<br>MYViv, Israe         |  |  |  |  |  |  |
| tor  | Usual Residence of Decedent  |  | 10d. Inside City Limits<br>1 X Yes 2 □ No   |   |   |  |  |  |  |  |  |  |
| al Director  | 10e. Street and Number<br>3414 Bradley Lane  |  | 10f. Zip Code<br>20815  |   |   |  |  |  |  |  |  |  |
| eted by Funeral  | 1 □ Never Married 2 ☒ Married 1 ☒ Ye   | 2 No WWII Dates: US Army 16a. Decer  | Was Decedent of Hispanic Origin? (Srif Yes, specify Cuban, Mexican, Puerform of the Specify:  I Specify:  dent's Usual Occupation kind of work done during most of work DO NOT use retired) | 16  | 14. Race - Ame<br>Black, Whit<br>Specify: | <sub>e, etc.</sub><br>White                      |  |  |  |  |  |  |
| Completed  | Elementary/Secondary (0-12)  College  College  Tather's Name (First, Middle, Last)   | mation Agenc   |   |   |   |  |  |  |  |  |  |  |
| To Be  | Joseph Brumberg  19a. Informant's Name/Relationship (Type. Print)  | Zip Code)  |   |   |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director                                | 19a. Informant's Name/Relationship (Type. Print)   19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State Z0011   20a. Method of Disposition   20b. Place of Disposition (Name of Cemetery, crematory or other place)   20b. Place of Disposition (Name of Cemetery, Crematory or other place)   20b. Lebanon Cemetery (Street and Number of Rural Route Number, City or Town, State 20011   20b. Place of Disposition (Name of Cemetery, Crematory or other place)   20b. Place of Disposition (Name of Cemetery, Crematory or other place)   20c. Location - City or Town, State Cemetery, Crematory or other place)   20c. Location - City or Town, State Cemetery, Crematory or other place)   20c. Location - City or Town, State Cemetery, Crematory or other place)   20c. Location - City or Town, State Cemetery, Crematory or other place)   20c. Location - City or Town, State Cemetery, Crematory or other place)   20c. Location - City or Town, State Cemetery, Crematory or other place)   20c. Location - City or Town, State Cemetery, Crematory or other place)   20c. Location - City or Town, State Cemetery, Crematory or other place)   20c. Location - City or Town, State Cemetery, Crematory or other place)   20c. Location - City or Town, State Cemetery, Crematory or other place)   20c. Location - City or Town, State Cemetery, Crematory or other place)   20c. Location - City or Town, State Cemetery, Crematory or other place)   20c. Location - City or Town, State Cemetery, Crematory or other place)   20c. Location - City or Town, State Cemetery, Crematory or other place)   20c. Location - City or Town, State Cemetery, Crematory or Other place)   20c. Location - City or Town, State Cemetery, Crematory or Other place)   20c. Location - City or Town, State Cemetery, Crematory or Other place)   20c. Location - City or Town, State Cemetery, Crematory or Other place)   20c. Location - City or Town, State Cemetery, Crematory or Other place)   20c. Location - City or Town, Company or Other place, Crematory or Other place, Cre |  |   |   |   |  |  |  |  |  |  |  |
| an<br>cal<br>ier   | 23a. Part1. Enter the disease, or complications tha shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  |  | Approximate Interval Between Onset and Death 5 days 4 weeks   |   |   |  |  |  |  |  |  |  |
| dical Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  Coronary Artery Disease  Due to (or as a consequence of):  d.   |  |   |   |   |  |  |  |  |  |  |  |
| ysician/Medical  | in the past 12 months?   | gnant at time of death 5   | Ectopic pregnancy Other (specify)   |   | 23d. Date of delivery  Month Day Year     |  |  |  |  |  |  |  |
| d by Phy   | Part II. Other significant conditions contributing to  | death but not resulting in the u   | nderlying cause given in Part I.  |   | cco use contribute to the cause of death? |  |  |  |  |  |  |  |
| Completed  | Cerebrovascular D  | isease   |   | 24a. Was an autopsy perform                           | 24b. Were a prior to death?               | utopsy findings available completion of cause of |  |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examin | 27. Manner of Death 1 Natural 5 Pending (M) 2 Accident investigation   | Inpatient 2 ER/Outpatier te of Injury onth, Day Year)  28b. Time o Injury ce of injury - At home, farm, stri Iding, etc. (Specify) | nt 3 DOA Other: 4 Nursing H  f 28c. Injury at Work?  M 1 Yes 2 No   | ath (Check only one lome 5 XResider 28d. Describe how | ) nce 6 □Other (Spevinjury occurred       | ocify)   |  |  |  |  |  |  |
| edical Cert  | 29a. Certifier Check only 2 Medical Examiner: On the   | he best of my knowledge, deat  | th occurred at the time, date and place   | e, and due to the ca                                  | use(s) and manner a                       |  |  |  |  |  |  |  |
| Medi   | one)  29b. Signature and title of certifier  |  | d. Date signed (Mon   |   |   |  |  |  |  |  |  |  |
|  | 30. Name and address of person who completed condition and Rogers, MD 5530   | uuse of death (Item 23a) (Type,<br>) Wisconsin Ave   | Print) #1400 , Chevy  | Chase, M  | D 20815                                   |  |  |  |  |  |  |  |
| State<br>gistrar   | 31. Date filed (Month, Day, Year) JAN 2 9 2008   | Registrar's Signature  | NE)   |   |   |  |  |  |  |  |  |  |

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 10:31 aM Charles G. Breslin January 24 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F Days Hours Min Director 73 184-32-2170 May 21, 1934 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 'natural', or items 23a or 28a-f shov idical Examiner must be notified at 1 ☐ Yes 2 No Director Pennsylvania Luzerne Mountain Top 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2853 Church Road 18707 II\_S\_A\_ Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: <sup>2</sup>□ No Korean 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: ģ 3 X Widowed 4 ☐ Divorced War White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If item 27 is marked other thx any injury or other traumatic event, the 12 Electrician Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Charles Jerome Breslin Janice Ella Weyhenmeyer 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Breslin - Son 4813 Gunbarrel Road, Springville, New York 14141 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation Removal from State 4 Donation 5 □ Other 01/30/2008 Specify) Fort Lincoln Crematory Brentwood, Maryland 21. Sgnature of Funeral Serv 22. Name and Address of Facility Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the is-ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailu e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fred disease or condition resulting in death) MVITIPLE MYELOMA Physician VRS. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box ( 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.0. the detached 9☐Unknown 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? EPTICEMIA 2 No 1 🗌 Yes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autops perform certificate Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 ☐ Yes ٩ 2 ER/Outpatient 3□ DOA To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di this 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Records, Division or Vital Breslin, Charle

A.M.A

3 10

30/12

State Registrar

Medical

VICTOR M. PRIEGO 31. Date filed (Month, Day, Year) 29 JAN

29b. Signature and title of certifier

29a. Certifier

(Check only one)

MA 2008

who completed cause of death (item 23a) (Type, Print)

6420 POCKLEDGE DR. #4100 32 Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

0-23308

29d. Date signed (Month, Day, Year) JAN. 25, 2008

RETHESOA, MO 2087

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 26, 2008 **Physician** 1040AM Alvin BERLIN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Brooke Grove Assisted Living Facility Spring Sandy Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑** M 2□ F Director 219-22-6434 April 23, 1923 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 20. . . . . any injury or other traumatic event. Its Maryland Once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Montaomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? <u> 15115 Interlachen Dr. #1009</u> 20906 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1V Yes 2 No If Yes, Give WW2 Year or Dates: WW2 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Pharmacist Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Nathan Berlin Sarah Snesil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Bonifant/ Son in law 15218 Golf View Dr. Haymarket, VA 20169 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State King David Memorial Gardens 1/28/08 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sovice House 22. Name and Address of Facility Igachinsky, Hebrew Numeral ndews, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Division of Vital Records, P.O. Box 68760, 23b. Did tobacco usa contribute to tha cause of daath? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown tem disease; hypertension Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Sther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1□ Yes 2No Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

211

State Registrar

31. Date filed (Month, Day, Year) JAN 29

30. Name and address of person who completed cause of death (Item 23a) (Type Print)
Gruce Browke Hoffman, M.D. 18100 Slade School Road Sandy Spring Mary 32. egistrar's Signature

un Staff Physician

**Funeral** 

|  | 1   | For<br>State<br>Registrar  |  |                         |  | ) IVIA      | ryiariu      |             | rtifica                 |                           |                |                                   | ientai H  | Reg. N  | 711                 | 108                      | 041                                  | 41           |
|--|---|--|--|-------------------------|--|-------------|--------------|-------------|-------------------------|---------------------------|----------------|-----------------------------------|---|---|---------------------|--------------------------|--------------------------------------|--------------|
| cian<br>dical                              |   |  | CE                                     |                         | BONI   |             | Ш            |             | T                       |                           |                |                                   | 2. Date of Month  | 25  |                     | Year                     | 1.77                                 | ₽M           |
| iner                                       | ľ   | 4a. Facility Name (/   |  | _                       |  | ımber)      |              |             | 4b. City                | Town, or                  | Location       | n of Death                        |   |   | 4c. County of Death |                          |                                      |              |
| and an                                     |   | 43945 Ma   |  |                         |  | 1           |              |             |                         | nard                      | -              |                                   | 10011   |   | t.Ma                | arys                     |                                      |              |
| al<br>or                                   |   | 5. Social Security N<br>214-46-6   | 345                                    | 6. Se                   | ex<br>XIM 2□F                                | 7. Age      | (In yrs. las | 1/          | Months                  |                           | Hours          | er 24 Hrs.<br>Min.                | 8. Date of Month,<br>Sept. 2  | Day, Year   | r)<br>. 7           | Coui                     | place (State or Fi<br>ntry)<br>yland | oreign       |
| once.  To Be Completed by Funeral Director |   | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |  |                         |  |             |              |             |                         |                           |                |                                   | 10d. Inside City I  |   |                     |                          |                                      |              |
| Director                                   |   | Md. St.Marys Leonardtown   |  |                         |  |             |              |             |                         |                           |                |                                   | 1 ★ Yes 2   | □140  |                     |                          |                                      |              |
| <u>ē</u>                                   |   | 10e. Street and Nu   | mber                                   |                         |  |             |              |             | 10f. Zi                 | Code                      |                |                                   |   | 10g. C  | itizen of           | f What Cou               | ntry?                                |              |
|  |   | 43945 M  | ain Wa                                 | v R                     | d.   |             |              |             |                         | 206.                      | 50             |                                   |   |   | U.S                 | S.A.                     |                                      |              |
| Funeral                                    | 1   | 11. Marital Status   |  |                         | 12. Was Dec                                  |             | ver in U.S.  | . 13        | . Was Dece              | dent of H                 | ispanic C      | Origin? (Sp                       | ecify Yes or<br>Rican, etc.)  | No-   |                     | ace - Ameri              |                                      |              |
| by Fur                                     |   | 1 ☐ Never Marr<br>3 ☐ Widowed  |  |                         | Armed F<br>1 ☐ Yes<br>If Yes, G<br>Year or I | 2⊠No<br>ive | 0            |             | 1 ☐ Yes                 |                           | Specif         |                                   | Rican, etc.)  |   | Spec                | ack, White,<br>sify: Whi | _                                    |              |
|  |   | (0   | 15. Decede                             | 5. Decedent's Education |  |             |              |             | edent's Usi             |                           |                | 4 - <b>-6</b>                     | de a  | 16b.  | Kind of             | Business/Ir              | ness/Industry                        |              |
| Se l                                       | -   |  |  | est grad                | de completed,                                |             |              | life.       | e kind of w<br>DO NOT ເ | ork aone d<br>ise retired | auring m<br>d) | ost of work                       | ang   |   |                     |                          |                                      |              |
| Completed                                  |   | Elementary/Secondary (0-12) College (1-4or 5+)   |  |                         |  |             |              |             | Meat                    | Mana                      | ager           |                                   |   | Gi  | ant                 | ant Food                 |                                      |              |
| Be C                                       |   | 17. Father's Name  | 7. Father's Name (First, Middle, Last) |                         |  |             |              |             |                         |                           | 18. Mot        | ther's Nam                        | e (First, Midd  | dle, Maide  | e, Maiden Surname)  |                          |                                      |              |
| To B                                       |   | Brice Bowie 11 Janet   |  |                         |  |             |              |             |                         |                           |                | Helb                              | Helbick   |   |                     |                          |                                      |              |
| -  | 1   | 19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Ru  |  |                         |  |             |              |             |                         |                           |                | nber or Rui                       | ral Route Nui   | nber, City  | or Tow              | n, State, Zi             | p Code)                              |              |
|  |   | _  |  |                         | (Daught                                      | tor)        |              |             |                         | •                         |                |                                   | ier Ci  |   |                     |                          |                                      | i            |
|  | -   | Stacey  20a. Method of Dis   |  | ng                      | (Daugii                                      | LEI)        | 20h Pla      |             | osition (Na             |                           | 16.            |                                   | Date  |   |                     | n - City or T            |                                      |              |
|  |   | 1⊠ Burial 2<br>4 □ Donation  | ☐ Cremation                            |                         |  | n State     | cei          | metery, ch  | ematory or              | other plac                |                |                                   |   |   |                     | •                        |                                      |              |
|  |   | 4 Donation 5 Other (Specify) Ft.Lincoln Cemetery Jan.30,2008 Brentwood, Md.  21. Signature of Funeral Service Licensee Chambers Funeral Home & Crematorium, P.A. 5801 Cleveland Ave.Riverdale, Md. 20737   |  |                         |  |             |              |             |                         |                           |                |                                   |   |   |                     |                          |                                      |              |
|  | 1   | 231. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between   |  |                         |  |             |              |             |                         |                           |                |                                   |   |   | on                  |                          |                                      |              |
|  | 1   | snock, or nea  |  | st only t               | one cause on                                 |             |              | TI          |                         | M                         |                |                                   |   |   |                     |                          | Onset and Dea                        | ath          |
|  | disease or condition a. DRAIN VAOR INTLIGATION OF LIMIT.  |  |  |                         |  |             |              |             |                         |                           |                | 2 M                               | 2 .   |   |                     |                          |                                      |              |
|  |   | Due to (or as a consequence of):   |  |                         |  |             |              |             |                         |                           |                |                                   |   |   |                     |                          |                                      |              |
| _  |   | Sequentially list conditions, bb.  |  |                         |  |             |              |             |                         |                           |                |                                   |   |   |                     |                          |                                      |              |
| Examiner                                   |   | If any, leading to immediate Due to (or as a consequence of):  Cause. Enter Underlying  Cause, Disease or injury   |  |                         |  |             |              |             |                         |                           |                |                                   |   |   |                     |                          |                                      |              |
| carr                                       |   | Cause (Disease or injury that initiated events c   |  |                         |  |             |              |             |                         |                           |                |                                   |   |   |                     |                          |                                      |              |
| ŵ  | Ì   | Tooling in addition  |  |                         | Due  | (or as a    | conseque     | ence or).   |                         |                           |                |                                   |   |   |                     |                          |                                      |              |
| edical                                     |   | d  |  |                         |  |             |              |             |                         |                           |                |                                   |   |   |                     |                          |                                      |              |
| Wec  |   | IE EEMALE:   |  | T                       |  |             |              |             |                         |                           |                |                                   |   |   |                     |                          |                                      |              |
| ician/M                                    |   | IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No  23c. If yes, outcome pf pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)  |  |                         |  |             |              |             |                         |                           |                |                                   | 23d. Date of delivery  Month Da   |   |                     |                          | ar                                   |              |
| Physi                                      |   | 9 Unknown  |  |                         |  |             |              |             |                         |                           |                |                                   |   |   |                     |                          |                                      |              |
| þ  |   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                         |  |             |              |             |                         |                           |                |                                   |   | 23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown |                     |                          |                                      |              |
| etec                                       |   |  |  | -                       |  |             |              |             |                         |                           |                |                                   |   |   |                     |                          |                                      | - 15 - 1 - 1 |
| Completed                                  |   |  |  |                         |  |             |              |             |                         |                           |                | ai<br>pi                          | 24a. Was an autopsy autopsy performed? 1□ Yes 2 No 1□ Yes 2 No 1□ Yes 2□ No |   |                     |                          |                                      |              |
| -  | 25. Was case referred to medical     26. Place of Death (Check only one)                              |  |  |                         |  |             |              |             |                         |                           |                |                                   |   |   |                     |                          |                                      |              |
| 70   |   | 1 Yes 2  | No                                     |                         | Hospital: 1 □                                | ] Inpatier  | nt 2 🗆 E     | R/Outpation | ent 3 🗆 🗅               | OA Oth                    | er: 4          | Nursing H                         | ome 5 R   | esidence  | 6 □0                | other (Spec              | ify)                                 |              |
|  | .   | 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?  |  |                         |  |             |              |             |                         |                           |                | 28d. Describe how injury occurred |   |   |                     |                          |                                      |              |
| Certification                              |   | 2 Accident investigation   Suicide   Suicide   Accident   Accident   Suicide   Suicide   Accident   Suicide   Suicid |  |                         |  |             |              |             |                         |                           |                |                                   | ral Route Numbe   | er,   |                     |                          |                                      |              |
|  |   | 29a. Certifier<br>(Check only  |  |                         |  | basis of    | examination  |             |                         |                           |                |                                   |   |   |                     |                          | stated.<br>to the cause(s)           |              |
| Medical                                    | one) and manner stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed ( |  |  |                         |  |             |              |             |                         |                           |                |                                   | ned (Month  | n, Day, Year)   |                     |                          |                                      |              |
|  |   | · W  | <b>.</b>                               |                         | 1  | 9           | -//          | 01          | 70                      | ſ                         | 705            | 15 8                              | 3   | /   | /21                 | 8/20                     | 08<br>RD<br>2070                     |              |
|  | -   | 1/10   | wey                                    | 11                      | D  | ren         | ger.         |             | "U                      | U                         | 1,3            | 6                                 | CHA   | 1   | -                   | 00                       | 00                                   |              |
|  |   | 30. Name and add   | lress perso                            | Z no                    | completed car                                |             |              |             |                         | -                         | 9/2            | 5                                 | 700   | Y   | 200                 | 11.1                     | 2 -                                  | 10           |
|  |   | MIRV   | ey                                     | 7                       | STEI   | NE          | CLO          | /7          | -12                     |                           |                |                                   | MA  | 216   | e                   | 1'd                      | 2076                                 | 6 9.         |
| tate<br>trar                               |   | 31. Date filed (Mor  | AN 2 9                                 |                         | 08   | registra    | i s signatt  | 5           | out                     | P                         |                |                                   |   |   |                     |                          |                                      |              |
|  |   |  |  |                         |  |             |              |             |                         |                           |                |                                   |   |   |                     |                          |                                      |              |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death -Month Physician Januari **JAMES** K. BATTLE SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE NONE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**X** M 2□ F Months Director 577-54-1683 69 NOV. 7, 1938 WASH. D.C. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other than the Medical Examiner must be notified at 10b. County 1 Yes 2 No Director MD. NONE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3915 CALLAWAY AVE. 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ▼ Yes 2 No 1957— If Yes, Give Year or Dates: 1959 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: þ 3 Widowed 4 Divorced 1959 **BLACK** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 LETTER CARRIER U.S. POST OFFICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ WILLIAM BATTLE BARNES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BATTLE JR./SON JAMES K. 10805 LEGEND MANOR LA., GLENN DALE, MD. 20769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) LINCOLN MEMORIAL CEM. 1-31-2008 SUITLAND, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A MO0091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Disease **Physician** Arteriosclerotic Cardiovascular years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-tran and Due to (or as a consequence of): attending physician Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Throat ancer 1 ☐ Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an NEAMONIC autopsy ffusior perform CUVa 2 X No 1 ☐ Yes 2 ☐ No 1∐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1 Inpatient P this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide

the death certificate be executed Division or Vital Records, P.O. Box 68760, Attending Physician:

3altimore, Maryland 21215-0036

XI

State

Medical

29a. Certifier

(Check only one)

30. Name and add

29b. Signature and title of certifier

31. Date filed (Month Day, Year)

JAN 2 9

2008

Registrar

DHMH 17 Rev 1/2001

ed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                               |  |                | For   |                                       | State  | of Mai                 | yland.                   | / Depa           | artment                              | of H                               | ealth a                |                                   | ental Hy  |                       | •                  | 04143  |  |  |
|-------------------------------|--|----------------|---|---------------------------------------|--|------------------------|--------------------------|------------------|--------------------------------------|------------------------------------|------------------------|-----------------------------------|---|-----------------------|--------------------|--|--|--|
| an                            | end it   | em             |   |                                       |  | 08,                    | eb                       | Cer              | tificate                             | e or L                             | Jeath                  |                                   |   | Reg. No.              |                    | 3. Time of Death                                   |  |  |
| н                             | Physicia   | an             |   | Decedent's Name (First, Middle, Last) |  |                        |                          |                  |                                      |                                    |                        | Date of Death     Month Day Yea   |   |                       |                    |  |  |  |
|                               | /Medic   | al             | Mildred V.  |                                       | eaucham  |                        |                          |                  | 45 005 3                             | r                                  | l ti                   | 4 D 4h                            | Januar  |                       | 2008 County of Dea | 12:25 PM   |  |  |
|                               | Examin   | G1             | 4a. Facility Name (If not ins   |                                       |  |                        |                          |                  |                                      |                                    | Location of            | of Death                          |   |                       |                    |  |  |  |
|                               | ,X:  |                | Friendship H 5. Social Security Number  | ouse F                                |  |                        | Ving<br>(In yrs. lasi    | t hirthday)      | If Under                             | rlin<br>1 Year                     | If Under               | 24 Hrs.                           | 8 Date of Bin   |                       | orceste            |  |  |  |
|                               | Funeral<br>Director  |                | 219-44-1576   |                                       | _M 20 <b>√</b> F   | 96                     |                          | Yrs.             | Months                               |                                    | Hours                  | Min.                              | 8. Date of Bin<br>(Month, Da<br>11-28-                                      |                       |                    | thplace (State or Foreign<br>ountry)<br>vland      |  |  |
| <u> </u>                      | - 10   |                | Usual Residence of Deced  | ent                                   |  | 90                     |                          |                  |                                      |                                    |                        |                                   | 11-20-  | 1711                  | <u> </u>           | утапо  |  |  |
|                               | nylan<br>how   |                | 10a. State 10b. 0   | County                                |  | own or Lo              | cation                   |                  |                                      |                                    |                        |                                   | 10d. Inside City Limits   |                       |                    |  |  |  |
|                               | e-fs   | cto            | MD Worcester Berlin   |                                       |  |                        |                          |                  |                                      |                                    |                        |                                   |   |                       | 1 AYes 2 No        |  |  |  |
|                               | or 28  | Director       | 10e. Street and Number  |                                       |  |                        |                          |                  | 10f. Zip                             |                                    |                        |                                   |   | 10g. Citi             | izen of What Co    | ountry?  |  |  |
|                               | filed within 72 hours after death with the Maryland<br>Hygiene.<br>other than "naturel", or items 23a or 28e-f show<br>ent, it is Modical Examination in Milled at   | ral            | 10602 Frie  | ndshi                                 |  |                        |                          |                  |                                      | 2181                               |                        |                                   |   |                       | USA                |  |  |  |
|                               | er de  | Funeral        | 11. Marital Status  |                                       | 12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No |                        |                          | 13. \            | Was Deced<br>f Yes, spec             | spanic Ori<br>n, Mexicar           | gin? (Spe<br>1, Puerto | cify Yes or No<br>Rican, etc.)    | or No-<br>ic.) 14. Race - American Indian,<br>Black, White, etc.            |                       |                    |  |  |  |
| 36                            | , or   | by F           | 1 Never Married 2   |                                       | If Yes, Give<br>Year or Dates:                           |                        |                          |                  | 1□Yes 2                              | Specify:                           |                        |                                   |   | Specify: Ta           | Thite              |  |  |  |
| 9                             | hour   | edt            | -   | ducation 16a Dec                      |  |                        | <br> 6a. Deced           | dent's Usua      | l Occupa                             | ation                              |                        |                                   | 16b. Ki   | ind of Business       |                    |  |  |  |
| 15                            | n ng   | plet           | (Specify only<br>Elementary/Secondary (   | highest gra                           | College (1-4or 5+) (Giv                                  |                        |                          | (Give<br>life. l | kind of wor<br>DO NOT us             | k done d<br>e retired              | turing mos<br>')       | t of worki                        | ng  |                       |                    |  |  |  |
| 212                           | yiene<br>r tha   | Completed      | 8   | 0-12)                                 |  |                        |                          |                  | maker                                |                                    |                        |                                   |   | Ow                    | n Home             | łome   |  |  |
| פ                             | e file<br>of he<br>vent.   | Be C           | 17. Father's Name (First, M   | Aiddle, Last)                         | t)   |                        |                          |                  |                                      |                                    | 18. Mothe              | er's Name                         | (First, Middle  | Maiden                | Sumame)            |  |  |  |
| <u>la</u>                     | Aenta<br>Aenta<br>rked<br>ric e  | To E           | Edward <del>Hroa</del>  | ee Pus                                | зеу  |                        |                          |                  |                                      |                                    | Heni                   | riett                             | etta Wright   |                       |                    |  |  |  |
| Maryland 21215-0036           | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydiene.  Department of Health and Mental Hydiene.  Importent: If item 27 is marked other than "naturel; or items 23a or 28e-f show any injury or other treumatic event. It is Not Extra in and it is notified at once. |                | 19a. Informant's Name/Re  |                                       |  |                        |                          |                  |                                      |                                    |                        |                                   | Rural Route Number, City or Town, State, Zip Code) ive, Salisbury, MD 21804 |                       |                    |  |  |  |
| Σ.                            | and salth<br>n 27 i  |                | Ruth Beauch   | amp/da                                | augnter  | -1n-                   | -                        |                  |                                      |                                    | rook                   |                                   |   |                       |                    |  |  |  |
| altimore,                     | of Ho  |                | 20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition cemetery, cremator |                                       |  |                        |                          |                  |                                      |                                    | e)                     |                                   | ate   | 20c. Lo               | ocation - City or  | Town, State  |  |  |
| Ē                             | Pag<br>ment<br>ent:<br>ury c   |                | `4 □Donation 5 □ O  |                                       |  |                        | Beec                     | hwoo             | d Cem                                | eter                               | y (                    | 1/25                              | /2008   | Pri                   | ncess A            | nne, Marylan                                       |  |  |
| Ball                          | epart<br>oport<br>ny in  |                | 21 Signature of Funeral S   | ervice Licen                          | see  | 2                      |                          | H                | Name and                             | Addres<br>Fun                      | s of Facilit           | Home                              | 1   |                       |                    |  |  |  |
|                               | 20E 5 3  | 7              | MANUAL X  | YU                                    | now  | // MO                  | 0295                     | 1                | 1672                                 | Como                               | ***                    | A 37.0                            | Drin  | cess                  | Anne,              | MD 21853   |  |  |
|                               |  | 1              | 2 a. Part1. Enter the dise<br>shock, or heart failur  | ase, or comp<br>e. List only          | one cau  | caused to<br>each line | he death.                | Do not ent       | er the mode                          | e of dyin                          | g, such as             | cardiac c                         | r respiratory a   | rrest,                |                    | Approximate<br>Interval Between<br>Onset and Death |  |  |
|                               | Physician  | 1              | Immediate Cause (Final METAS TATIL (  |                                       |  |                        |                          |                  |                                      | CANCER                             |                        |                                   |   |                       |                    |  |  |  |
|                               | /Medical<br>Examiner   |                | resulting in death)  Due to (or as a consequence of):   |                                       |  |                        |                          |                  |                                      |                                    |                        |                                   |   |                       |                    |  |  |  |
|                               | Lxammer  | _              | Sequentially list conditions  | C                                     | CANCER   |                        |                          |                  |                                      |                                    |                        |                                   |   |                       |                    |  |  |  |
|                               | od sit   | Examiner       | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury          | nce of):                              |  |                        |                          |                  |                                      |                                    |                        |                                   |   |                       |                    |  |  |  |
|                               | and<br>and<br>I-tran   | хап            | that initiated events resulting in death) Last Due to (or as a consequence of):                                     |                                       |  |                        |                          |                  |                                      |                                    |                        |                                   |   |                       |                    |  |  |  |
| 760,                          | ficate be executed<br>physician and<br>is the burial-transit   | calE           |   |                                       | 540 10   | (0.000                 |                          |                  |                                      |                                    |                        |                                   |   |                       |                    |  |  |  |
| 687                           | physis the   |                |   |                                       | d  |                        |                          |                  |                                      |                                    |                        |                                   |   | 1.1                   |                    |  |  |  |
| 9 ×                           | The law requires that the death certifica<br>Ite has been signed by the attending ph<br>tage 2 should be detached for use as th  | Physician/Med  | IF FEMALE: 23c. If yes, outcome of pregnancy  |                                       |  |                        |                          |                  |                                      |                                    |                        |                                   |   | 23d. Date of delivery |                    |  |  |  |
| Вох                           | atten<br>for u   | clan           | 23b. Was decedent pregn<br>in the past 12 months  |                                       |  |                        |                          |                  | □Ectopic pregnancy □ Other (specify) |                                    |                        |                                   |   |                       | Month Day Year     |  |  |  |
| <u>о</u> .                    | the d  | ıysi           | 1 ☐ Yes 2 🗹 No<br>9 ☐ Unknown   |                                       | 9□ Unkr  |                        |                          |                  |                                      | ,,                                 |                        |                                   |   |                       |                    |  |  |  |
|                               | res that<br>igned b  | y P            | Part II. Other significant of   | onditions o                           | contributing to death but not resulting in the underlyi  |                        |                          |                  |                                      | erlying cause given in Part I.     |                        |                                   | 23e. Did tobacco use  |                       | use contribute t   | se contribute to the cause of death?               |  |  |
| Sp.                           | uires<br>sign  | d by           |   |                                       |  |                        |                          |                  |                                      | 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Un |                        |                                   |   |                       |                    |  |  |  |
| Records,                      | w require<br>been si<br>should t   | Completed      |   |                                       |  |                        |                          |                  |                                      |                                    |                        |                                   | 24a. Was  | an                    | 24b. Were a        | utopsy findings available                          |  |  |
| Re                            | sicien: The law<br>certificate has k<br>irector, page 2 s  | m              |   |                                       |  |                        |                          |                  |                                      |                                    |                        | auto<br>perfe                     | completion of cause of  |                       |                    |  |  |  |
| Vital                         | iffication, per  | e<br>C         | 25. Was case referred to medical examiner?  1   |                                       |  |                        |                          |                  |                                      |                                    |                        | of Death                          | 1 Yes 2 No 1 Yes 2 No   |                       |                    |  |  |  |
|                               | Physicien:<br>r this certific<br>ral director,   | 0 B            |   |                                       |  |                        |                          |                  |                                      |                                    |                        |                                   |   |                       |                    |  |  |  |
| ō                             | tending Physicien: The leath. tor: After this certificate hathe funeral director, page   | Ë              |   |                                       |  |                        |                          |                  |                                      |                                    |                        | 28d. Describe how injury occurred |   |                       |                    |  |  |  |
| Division of or Attending Phys | nding<br>th.<br>r: Afte<br>e fun   | atio           | 1 X Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No                  |                                       |  |                        |                          |                  |                                      |                                    |                        |                                   |   |                       |                    |  |  |  |
| N S                           | 4 0 0  | ifica          | 3 ☐ Suicide 6 ☐<br>4 ☐ Homicide   | Could not be determined               | 286. Plac  | e of Injur             | y - At home<br>(Specify) | e, farm, str     | reet, factory                        | , office                           |                        |                                   | 28f. Location (<br>City or To   |                       |                    | Rural Route Number,                                |  |  |
|                               | el or<br>s afte<br>si Dir  | Certification: | 4 E Homelde   |                                       | Duile  | Jilly, etc.            | (Specify)                |                  |                                      |                                    |                        |                                   | Only of 10  | wii, otale            | ,,                 |  |  |  |
|                               | ospit<br>hour<br>unere<br>ly fille   |                |   |                                       |  |                        |                          |                  |                                      |                                    |                        |                                   |   |                       | ) and manner a     | s stated.<br>e to the cause(s)                     |  |  |
|                               | To the Hospitel or At within 24 hours after o To the Funerel Direct completely filled in by  | Medical        | one)  |                                       | and mai  | nner state             | ed.                      | 1 and/or in      |                                      |                                    |                        | - OCCUIT                          | ed at the time,   |                       |                    |  |  |  |
|                               | To T   | Σ              | 29b. Signature and title of certified 4   |                                       |  |                        |                          |                  |                                      | e number                           | GA                     |                                   | 29d. Da   | te signed (Mon        | (Month, Day, Year) |  |  |  |
|                               |  |                | /   | 10 4                                  | 81   | 1'                     | ν.                       |                  |                                      |                                    |                        |                                   |   |                       | 24-                |  |  |  |
|                               |  |                | 30. Name and address of   | person to                             | completed cau  | se of de               | ath (Item 2              | За) (Туре,       | Print)                               | 1 11                               | , 40                   | 15                                | 34120   | IN                    | MN.                | 21811  |  |  |
|                               |  |                |   |                                       |  |                        |                          |                  |                                      |                                    | 100                    | -/                                | 1~/( )  | ,                     | , , ,              | - ' ' /  |  |  |
| **                            | Sta<br>Registr   |                | 31. Date filed (Month, Day  | 3 0                                   | 2008   | Medistrar              | 's Signatur              | &                | Spark                                |                                    |                        |                                   |   |                       |                    |  |  |  |
|                               | <u> </u>   |                |   |                                       |  |                        |                          | -                | The said                             |                                    |                        |                                   |   |                       |                    |  |  |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician Ам 30 2008 30 January Henry Lee Brown, II /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1004 Stoddert Court Charles Waldorf If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months 1 X M 2 □ F Yrs. Director 225-54-7428 October 2. 1940 Virginia 67 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show sdical Examiner must be notified at 1 X Yes 2 □ No Directo Charles Waldorf Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20602 USA 1004 Stoddert Court Funeral Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within tent of Health and Mental Hygiene. nt: If Item 27 is marked other than ' College (1-4or 5+) the Steamfitters Union Refrigeration Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Lee Brown, I Mary C. Crist Brown ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trat once. Elizabeth B. Brown/ Wife 1004 Stoddert Ct., Waldorf, Maryland, 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State rematory Jan.31, 2008 Waldorf 22. Name and Address of Facility Huntt Funeral Home Huntt Crematory 2008 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Cicensee Jel 502 30**3**5 Old Washington Rd. Waldorf, Maryland, 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the n shock, or heart failure. List only one cause on each line. ode of dying, such\_as cardiac or respiratory arrest, Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) KMOW **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy or Attending Physician: funeral director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c License number 29d. Date signed (Month, Day, Year) 29b. Signatu nd title of certifier who completed 23a) (Type, Print) dress of perso e of death

State

Registrar

31. Date filed (Month, Day,

Year.

2008

JAN 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 8:30 A<sup>M</sup> Javier Eduardo Bartrina Bancell January 25, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Westminster Carrol1 Social Security Number 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Hours **Director** 216-69-4037 77 May 14, 1930 Spain Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Directo MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 9389 Furrow Avenue 21042 Spain Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1X Yes 2□ No Specify Completed by 3 Widowed 4 Divorced Year or Dates: Spaniard White "natural"; er than "natur the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Petroleum Engineer Petroleum 27 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andres Bartrina Arisso Maria del Patrocino Bancell Santos မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9389 Furrow Avenue Ellicott City, MD 21042 Mercedes Bartrina/wife item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If it
any Injury or o 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | 01/28/08 Beltsville, MD 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Se MO1251 Beverly L. Heckrotte, P.A. Clarksville. MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or a a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Physician/Medical Exam burial-trar Due to (or as a consequence of): Box 68760. physician the IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) ed by the a Division or Vital Records, P.O. 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by sign( 1 | Yes 2 | No 3 | Probably 4 | Junknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ate has l performe 2 1 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 1 ☐ Yes Certification: To 6 Dother (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospir 1 Natural 5 Pending investigation iours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

1086

within 2 To the

State Registrar

Name and address

of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

29d. Date signed (Month, Day, Year)

xouth

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| 04146 |  | 0 | 1.3 | Bertrianich |  | 6 |
|-------|--|---|-----|-------------|--|---|
|-------|--|---|-----|-------------|--|---|

|                     |  |                  | For<br>State<br>Registrar  | State of Wi  | -                                 | Certificate   |                    |                     | , ,                           | eg. No.                             |                                       |  |  |  |
|---------------------|--|------------------|--|--|-----------------------------------|---|--------------------|---------------------|-------------------------------|-------------------------------------|---------------------------------------|--|--|--|
|                     |  |                  | 1. Decedent's Name (First, Middle, Las   | it)  |                                   |   |                    | 2.                  | Date of Deat<br>Month         |                                     |                                       |  |  |  |
|                     | Physici<br>/Medic  |                  | Mary F. Cooney   | •  |                                   |   |                    |                     | January                       |                                     | 1.4                                   |  |  |  |
|                     | Examin   |                  | 4a. Facility Name (If not institution, give  | street and number)   |                                   | 4b. City, To  | vn, or Location    | n of Death          |                               | 4c. County of De                    |                                       |  |  |  |
|                     |  |                  | 7405 Vinyard Cour  | t  |                                   |   | erwood             |                     |                               | Montgomery                          |                                       |  |  |  |
|                     | Funeral  |                  | Social Security Number     6. S  | ex 7. Ag<br>□M 2 🗓 F   | e (In yrs. last bir               | Months D  | ear If Unde        | Min.                | Date of Birth<br>(Month, Day, | Year) 9. E                          | Birthplace (State or Foreign Country) |  |  |  |
|                     | Director   |                  | 012-30-6340  | 241  | 70                                | Yrs.  |                    | A                   | ugust                         | 27,1937                             | MA                                    |  |  |  |
|                     | and w  |                  | Usual Residence of Decedent  10a. State 10b. County                                |  | 10c. City, Town                   | n or Location   |                    |                     |                               |                                     | 10d. Inside City Limits               |  |  |  |
|                     | Aaryl<br>f sho   | ō                | MD Montgom   | 10 <b>2</b> 77   | Т                                 | erwood  |                    |                     |                               |                                     | 1 ☐ Yes 2x No                         |  |  |  |
|                     | the 1  | ect              | 10e. Street and Number   | iery   |                                   | 10f. Zip Co   | de                 |                     | 1                             | 0g. Citizen of What                 | Country?                              |  |  |  |
|                     | with<br>Se or  | 0                | 7405 Vinyard Cour  | ·t   |                                   |   | 855                |                     |                               | United S                            |                                       |  |  |  |
|                     | ns 2   | Funeral Director | 11. Marital Status   | 12. Was Decedent   | Ever in U.S.                      | 13. Was Deceden If Yes, specify                                   |                    | Origin? (Specify    | Yes or No-                    | 14. Race - A                        | merican Indian,                       |  |  |  |
| မွ                  | within 72 hours after death with the Maryland<br>piene.<br>r then "neturel", or Items 23e or 28e-f show<br>Ite Madical Exertinast be rediffed at | Fur              | 1 ☐ Never Married 2 X Married  | Amed Forces?   |                                   |   |                    |                     | an, etc.)                     | Black, W                            |                                       |  |  |  |
| 8                   | ours a   | by               | 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates:                                 |                                   | 1 ☐ Yes 2 🔀   | No Specii          | у:                  |                               | Specify:                            | White                                 |  |  |  |
| 5-0                 | 72 ho  | Completed        | 15. Decedent's Ed<br>(Specify only highest gra                                     |  | 16 <i>a</i> .                     | Decedent's Usual C<br>(Give kind of work of<br>life. DO NOT use r | ccupation          | ost of working      |                               | 16b. Kind of Busine                 | ss/Industry                           |  |  |  |
| 21                  | within<br>ene.<br>then "   | ηb               | Elementary/Secondary (0-12)  | College (1-4or   | 5+)                               | Mother  | etired)            |                     |                               | Own Home                            |                                       |  |  |  |
| 2                   | filed w<br>Hygier<br>other ti  |                  | 17. Father's Name (First, Middle, Last)  | 4  |                                   | TIOCHEL   | 10 140             | hada Nama <i>(E</i> | Tent Adiabatio A              | Maiden Sumame)                      | -<br>-                                |  |  |  |
| anc                 | d la d   | Be               | Joseph Fitzsimmon  |  |                                   |   |                    | lara Le             |                               | naideri Sullialile)                 |                                       |  |  |  |
| Ë                   | should by<br>and Menta<br>s marked<br>umetic ev  | To               | 19a. Informant's Name/Relationship (7  |  | 10h                               | . Mailing Address (S  |                    |                     |                               | City or Town State                  | Zin Codol                             |  |  |  |
| Maryland 21215-0036 | d 2 sho<br>th and<br>th and<br>7 is ma<br>treum  |                  | Richard E. Coone   |  |                                   | 05 Vinyar   |                    |                     |                               |                                     |                                       |  |  |  |
|                     | is 1 and 2 should<br>of Health and Mer<br>item 27 is marke<br>other treumetic  |                  | 20a. Method of Disposition   | nasba  | 20b. Place of                     | Disposition (Name   | of .               | Date                |                               | 20c. Location - City                |                                       |  |  |  |
| Baltimore,          | permit. Pages : Department of H Importent: If ite eny injury or ot   |                  | 1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify                       |  |                                   | ry, crematory or othe<br>ouls Ceme                                |                    | Januar<br>200       | y 31                          | Cermantow                           | n, Maryland                           |  |  |  |
| Ħ                   | nit. F<br>artme<br>orter<br>injur  |                  | 21. Signature of Emeral Service Licen  |  |                                   | 22. Name and A  |                    |                     | 8 _                           | GCIMATICOW                          | ii, naryrand                          |  |  |  |
| ä                   | Depa<br>Impo<br>eny ir   |                  | Town TO X  | Je Not   |                                   | DeVol Fu  | neral              | Home, 1             | 0 East                        | Deer Par<br>MD 20877                | rk Drive,                             |  |  |  |
|                     |  |                  | 23a. Part1. Enter the disease, or companies shock, or heart failure. List only     | plications that cause  | the death. Do                     | not enter the mode o  | f dying, such a    | as cardiac or re    | espiratory arre               | est,                                | Approximate<br>Interval Between       |  |  |  |
|                     | Pnysician  |                  | Immediate Cause (Final disease or condition  |  |                                   | Colon Can   | nor                |                     |                               |                                     | Onset and Death  1 Year               |  |  |  |
|                     | /Medical   |                  | resulting in death)  | u  | a consequence                     |   | -61                |                     |                               |                                     | 1 Teal                                |  |  |  |
| П                   | Examiner   |                  | Conventinily list conditions   | b  |                                   |   |                    |                     |                               |                                     |                                       |  |  |  |
| _                   | D ==   | ner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as  | a consequence                     | of):  |                    |                     |                               |                                     |                                       |  |  |  |
|                     | cate be executed<br>physician and<br>the burial-transit  | Examine          | that initiated events<br>resulting in death) Last                                  | c  |                                   |   |                    |                     |                               |                                     |                                       |  |  |  |
| 30,                 | oe ex<br>cian a  |                  | 1650ming in doddiny Edist  | Due to (or as  | a consequence                     | or):  |                    |                     |                               |                                     |                                       |  |  |  |
| 68760,              | cate I   | Medical          |  | d  |                                   |   |                    |                     |                               |                                     |                                       |  |  |  |
|                     | n certific<br>anding p<br>use as   |                  | IF FEMALE:   | 23c. If yes, outcome   | of pregnancy                      |   |                    |                     |                               | 22d Data of                         | dolivon                               |  |  |  |
| Вох                 | atte<br>atte<br>for  | Physician/       | 23b. Was decedent pregnant in the past 12 months?                                  |  | 2 Fetal death                     | 3 □Ectopic pregr  |                    |                     |                               | 23d. Date of e                      | Day Year                              |  |  |  |
| Ö                   | at the de<br>by the a<br>tached  | ysi              | 1 ☐ Yes 2 ☒ No<br>9 ☐ Unknown  | 9□ Unknown   |                                   |   | ,,                 |                     |                               |                                     |                                       |  |  |  |
| <u>α</u>            | that<br>led b<br>deta  |                  | Part II. Other significant conditions of   | ontributing to death b   | ut not resulting in               | n the underlying caus   | e given in Par     | t I.                | 23e. Did tob                  | pacco use contribute                | to the cause of death?                |  |  |  |
| Records,            | quires<br>n sign<br>ald be   | d by             |  |  |                                   |   |                    |                     | 1 □ Ye                        | es 2 <b>1</b> No 3 □                | Probably 4 Unknown                    |  |  |  |
| 00                  | aw requir<br>is been si<br>2 should  | ompleted         |  |  |                                   |   |                    |                     | 24a. Was a                    | n 24b. Were                         | autopsy findings available            |  |  |  |
| Re                  | The la   | mo               |  |  |                                   |   |                    |                     | autops<br>perform             | y prior 1<br>ned? death<br>2☑No 1☐Y |                                       |  |  |  |
| Vital               | icien:<br>certifica<br>rector, p   | e C              | 25. Was case referred to medical   |  |                                   |   | 26. Pla            | ce of Death (C      |                               |                                     |                                       |  |  |  |
| >                   | × ∞ 5  | To B             | examiner?<br>1 ☐ Yes 2 🛣 No  | Hospital: 1 ☐ Inpatio  | ent 2 ER/Ou                       | itpatient 3 DOA   | Other: 4 🗆 I       | Nursing Home        | 5 🔀 Reside                    | ence 6 Other (S                     | pecify)                               |  |  |  |
| lof                 |  |                  | 27. Manner of Death 1 XNatural 5 ☐ Pending   | 28a. Date of Inju<br>(Month, Da                                |                                   | Time of 28c.  | Injury at<br>Work? | 280                 | l. Describe ho                | w injury occurred                   |                                       |  |  |  |
| 300                 | Attending r death. ector: After by the fune  | atle             | 2 Accident investigation   | 1  |                                   | М   | 1 Tes 2            | □No                 |                               |                                     |                                       |  |  |  |
| Division            | l or Att<br>after de<br>Directe<br>I in by t   | Certification;   | 3 ☐ Suicide 6 ☐ Could not be determined  | 28e. Place of in   | ury - At home, fa<br>c. (Specify) | rm, street, factory, o  | ffice              | 28f.                | Location (St. City or Town    |                                     | Rural Route Number,                   |  |  |  |
| ۵                   | oltel curs af  |                  |  |  |                                   |   |                    |                     |                               |                                     |                                       |  |  |  |
|                     | To the Hospitel or /<br>within 24 hours after<br>To the Funerel Dire<br>completely filled in b   | edical           |  | ysician: To the best<br>niner: On the basis o<br>and manner st | f examination an                  |   |                    |                     |                               |                                     |                                       |  |  |  |
|                     | To the within 2 To the Comple  | Me               | 29b. Signature and title of certifier  |  |                                   | 29c. L  | icense numbe       | r                   | 2                             | 9d. Date signed (Mo                 | onth, Day, Year)                      |  |  |  |
| )                   |  |                  | 1 Thorne   | - 209  | $\sim$                            |   | X4308              | 50                  |                               | 1/28/                               | 08                                    |  |  |  |
|                     | (D   |                  | 30. Name and address of person who   | completed cause of c   | leath (Item 23a)                  | (Type, Print)   | TDV +              | 1000                | William Co.                   | TMD 0                               | n(Z7)                                 |  |  |  |
|                     |  |                  | 31. Date filed (Month, Day, Year)  | 970 1  | MEDIC                             | IN UIN  | ICK VI             | L, KUC              | KVILL                         | 3 MAD 2                             | 0870                                  |  |  |  |
|                     | Sta<br>Registr   |                  |  | .008 32. ogisti  | ar's Signature                    | Apartie   |                    |                     |                               |                                     |                                       |  |  |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |                   | State of Maryland / Department of Health a State of Maryland / Department of Health a Certificate of Death  |                        | ygiene<br>Reg. No. 2 (              | 108 04147  |
|--|-------------------|---|------------------------|-------------------------------------|--|
| Physi  | cian              | Decedent's Name (First, Middle, Last)   | 2. Date of D           | Day                                 | 3. Time of Death   |
| /Med   |                   | Lynn Ross Cheezum   | Janua                  | ry 26, 2                            | 008 2:05a <sup>M</sup>   |
| Exam   | iner              | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location  | of Death               | 4c. County                          | y of Death   |
| Funera   |                   | Montgomery Hospice-Casey House  5. Social Security Number  6. Sex 7. Age (In yrs. last birthday) If Under Year 1rUnder  12. Months Days Hours   | Min. (Month, I         | ay, rear,                           | 9 Birthplace (State or Foreign<br>Country)                                   |
| Directo  |                   | 218-03-2940   | May 2                  | 6, 1919                             | Maryland   |
| yland<br>now   |                   | 10a. State 10b. County 10c. City, Town or Location  |                        |                                     | 10d. Inside City Limits  |
| a-f st   | 100               | Maryland Montgomery Germantown  |                        |                                     | 1 ☐ Yes 2 🛣 No   |
| or 28  | Director          | 10e. Street and Number 10f. Zip Code  |                        | 10g. Citizen of                     | What Country?  |
| ath w<br>23a<br>ust b  | <u>2</u>          | 12513 Milestone Manor Lane 20876  |                        |                                     | SA   |
| s 1 and 2 should be filed within 72 hours after death with the Maryland so 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. The solution is a second solution and solution at the manual to event, the Medical Examiner must be notified at  | by Funeral        |   |                        | Bla                                 | ce - American Indian,<br>ck, White, etc.<br>fy: White                        |
| hour<br>tural  |                   | 15. Decedent's Education 16a. Decedent's Usual Occupation   |                        | 16h Kind of B                       | dusiness/Industry  |
| in 72<br>in 72<br>in 74<br>in Medic  | Completed         | (Specify only highest grade completed)  (Give kind of work done during most life. DO NOT use retired)   | st of working          | 1                                   | dical Service  |
| with<br>jiene.<br>r thar   | E                 | Elementary/Secondary (0-12)  College (1-4or 5+)  4  Colonel   |                        | Corpor                              |  |
| buld be filed with<br>Mental Hygiene.<br>arked other thar<br>atic event, the N   | BeC               | 17. Father's Name (First, Middle, Last)  18. Moth   | er's Name (First, Midd |                                     |  |
| should be<br>nd Mental<br>marked oumatic ev  | - E               | William Phillip Cheezum Held  | en Ross                |                                     |  |
| 2 should be filed<br>and Mental Hygi<br>Is marked other<br>aumatic event, it   | -                 | 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Numb  |                        |                                     |  |
| 1 and 2<br>Health<br>em 27   |                   |   |                        | ne, Germa                           | antown, MD 20876   |
| permit. Pages 1 ar<br>Department of Hea<br>Important: If item<br>any injury or othe  |                   | 4 □ Donation 5 □ Other (Specify)  | March 18,              |                                     | - City or Town, State  |
| rmit.<br>partn<br>porta<br>y inju  | ,<br>Olice        | 21. Signature of Funeral Service Licensee 22. Name and Address of Facili Francis J. Co.   | lity                   |                                     | g <del>ton, Virginia</del><br>Tnc  |
| 88268  | 5                 | James Solo 500 University   |                        |                                     |  |
|  |                   | 23a. Part1. Enter the disease, or complications that call led the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.   |                        |                                     | Approximate<br>Interval Between  |
| Physician  | 1                 | Immediate Cause (Final disease or conditiona. Feritonitis   |                        |                                     | Onset and Death  |
| /Medica  | _                 | resulting in death)  Due to (or as a consequence of):   |                        |                                     |  |
| Examine  | <b>.</b>          | Sequentially list conditions, b.  |                        |                                     |  |
| sit ed   | ine               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in judy that initiated evenity co.   |                        |                                     |  |
| icate be executed physician and sthe burial-transit  | Examiner          | that initiated events resulting in death) Last  C   |                        |                                     |  |
| be e   |                   |   |                        |                                     |  |
| ficate<br>phys   | edical            | d.  |                        |                                     |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/M       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)     |                        |                                     | ate of delivery<br>onth Day Year   |
| hat the  | P                 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part   | 23e Die                | I tobacco use con                   | tribute to the cause of death?   |
| signe<br>d be c  | à                 | Tart is Other signmount conditions continuously to death but not resulting in the discerning dadse given in Fall  |                        |                                     | 3 ☐ Probably 4 ☐ Munknown  |
| requ   | Completed         |   | I barre                | 7                                   |  |
| e law<br>has l   | jau               |   | 24a. Wa                | is an 24b.<br>topsy<br>rformed?     | Were autopsy findings available<br>prior to completion of cause of<br>death? |
| n: Th<br>licate<br>r, pag  |                   |   | 1□ Yes                 | 2 xNo                               | 1 Yes 2 No   |
| sicial<br>certii<br>recto  | Be                | examiner?  Hospital: Other:   | e of Death (Check onl) |                                     |  |
| ding Physical After this funeral di  | Certification: To | 27. Manner of Death 1 Standard 5 Pending (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?   |                        | sidence 6 klOt<br>e how injury occu |  |
| death<br>ctor:<br>y the  | Cal               | 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office  | -                      | (Street and Num                     | ber or Rural Route Number,   |
| lor A<br>after<br>Dire   | ertii             | 4 Homicide determined building, etc. (Specify)  | City or T              | own, State)                         |  |
| Hospita<br>24 hours<br>Funeral   | Medical Co        | 29a. Certifier (Check of one)  1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date a 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated. |                        |                                     |  |
| o the<br>nithin<br>o the   | Mec               | 29b. Signature and title of certifier 29c. License number   |                        | 29d. Date signe                     | ed (Month, Day, Year)  |
| 15+1   |                   | Grenerel/rollars ms   | D64615                 | _                                   | ary 29, 2008   |
| -  |                   | Genevieve Wroblewski, MD 6001 Muncaster Mill Ro   | oad, Rockv             | ille, MD                            | 20855  |
| S<br>Regis   | tate<br>trar      | 31. Date filed (Month, Day, Year)  JAN 2 9 2008  32 Tegistrar's Signature   |                        |                                     |  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|             |  |                | For<br>State<br>Registrar   | State                  | of Mary                        |   | artment of<br>rtificate of            | Health and <b>N</b><br>Death                | -                            | giene<br>Reg. No.        | 008   | 04148   |
|-------------|--|----------------|---|------------------------|--------------------------------|---|---------------------------------------|---|------------------------------|--------------------------|---|---|
|             |  |                | 1. Decedent's Name (First, Middle, L  | ast)                   |                                |   |                                       |   | 2. Date of De                | ath<br>Day               | Yeer  | 3. Time of Death                              |
|             | Physici<br>/Medio  |                | Margar  | et C. So               | cafone                         | 9                                       |                                       |   | Januar                       |                          | 2008  | 10:10 A M                                     |
|             | Examin   |                | 4a. Facility Name (If not institution, g  | ive street and nu      | mber)                          |   | 4b. City, Town,                       | or Location of Death                        |                              | 4c. C                    | ounty of Death                                      |   |
|             |  |                | Austoria House  |                        |                                |   | Fult                                  | ton   |                              |                          | Howard  |   |
|             | Funeral  |                |   | Sex<br>1 □ M 2 🖫 F     |                                | yrs. last birthday)                     | If Under 1 Yea Months Days            |   | 8. Date of Bir<br>(Month, Da | v. Year)                 | 9. Birth  | place (State or Foreign<br>intry)             |
|             | Director   |                | 577 28 8785   | 1 M 2 Q                | 85                             | Yrs.                                    |                                       |   | Aug 20                       | , 192                    | 22   Was  | hington DC                                    |
|             | and w  |                | Usuel Residence of Decedent  10a. State 10b. County   |                        | 10                             | c. City, Town or Lo                     | ocation                               |   |                              |                          |   | 10d. Inside City Limits                       |
|             | Aaryli<br>Febr   | ö              | MD Herrard  |                        | ١,                             | Ellianet                                | C: +                                  |   |                              |                          |   | 1 ☐ Yes 2 🙀 No                                |
|             | 28a-   | Director       | MD Howard  10e. Street and Number   |                        |                                | Ellicott                                | 10f. Zip Code                         |   |                              | 10g. Citize              | en of What Cou                                      | intry?  |
|             | with<br>Sa or  |                | 4673 Columbia Ro  | ad                     |                                |   | 2104                                  |   |                              | Uni                      | ited St   | ates  |
|             | be filed within 72 hours after death with the Maryland ital Hygiene. dother than "natural", or Items 23a or 28s-f ehow event, the Medical Examinar must be incitited at  | Funeral        | 11. Marital Status  | 12. Was Dec            |                                | in U.S. 13.                             | Was Decedent of                       | Hispanic Origin? (S)                        | pecify Yes or No             |                          | 1. Race - Amer                                      | ican Indian,                                  |
| 5           | or Ite   |                | 1 Never Married 2 Married   | Armed F                | 2 X No                         |   |                                       | ban, Mexican, Puerto                        | Hican, etc.)                 |                          | Black, White  | , etc.  |
| 200-01717   | hours after<br>tural; or ite   | by             | 3X Widowed 4 ☐ Divorced   | If Yes, G<br>Year or [ |                                |   | 1⊡Yes 2⊠ No                           | o Specify:                                  |                              |                          | Specify: Wh   | ite   |
|             | 72 ho  | Completed      | 15. Decedent's (Specify only highest of   |                        |                                | 16a. Dece<br>(Give                      | dent's Usual Occi                     | upation<br>e during most of work<br>ed)     | king                         | 16b. Kind                | d of Business/l                                     | ndustry                                       |
| 7           | within 72<br>ene.<br>than na   | ldu            | Elementary/Secondary (0-12)   |                        | 1-4or 5+)                      |   |                                       | red)  |                              | _                        | TT  |   |
|             | iled v<br>tygie<br>her ti  |                | 12 17. Father's Name (First, Middle, Las  | •#1                    |                                | HOM                                     | emaker                                | 18. Mother's Nam                            | ne (First Middle             |                          | vn Home   | •   |
|             |  | Be             | Ellsworth Condro  |                        |                                |   |                                       | Helen Mo                                    |                              | , mason b                | omano,  |   |
|             | should Ind Men   | 2              | 19a. Informant's Name/Relationship  |                        | _                              | 19h Maili                               | na Address (Stree                     | et and Number or Ru                         |                              | er City or               | Town State 7  | in Code)                                      |
| Mal         | nd 2 sho<br>alth and<br>27 is m  |                | Daniel G. Scafon  |                        |                                |   |                                       | a Road Ell                                  |                              |                          |   |   |
|             | the the  |                | 20a. Method of Disposition  | C/ DOI1                | 2                              | Ob. Place of Dispe                      | osition (Name of                      | - !   | Date                         | _                        | ation - City or T                                   |   |
| 2           | Pages<br>nent of<br>int: If it   |                | 1 Surial 2 Cremation 3  3 4 Donation 5 Dother (Special Control Contro |                        | State                          | Gate of                                 | matory`or other pi                    |   | -2008                        | Whea                     | iton, M   | )   |
| Dalkillore, |  |                | 21. Signeture of Funeral Service Lic  |                        | -                              |   |                                       |   |                              |                          |   | ily FH Inc.                                   |
| מ           | permit. Departr Imports eny inji   |                | New Collins   | -all                   | Z M                            | 01044                                   | 112 Old                               | Columbia                                    | гу п. w<br>Pike El           | licot                    | t City  | , MD 21043                                    |
| 9,00,       | Physician /Medical Examiner  the private and physician and the private in the pri | dlcai Examiner | shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a                      | (or as a co                    | insequence of):  Dia (- insequence of): | retic (a<br>Dem                       | irdio van<br>untis<br>Mellit                | cular<br>ins                 | Dego                     | (400  | Interval Between<br>Onset and Death           |
| .O. DOY 0   | the death certifi<br>y the attending<br>iched for use as   | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   |                        | birth 2 🗀<br>nant at time      | Fetal death 3                           | ⊒Ectopic pregnan<br>□ Other (specify) |   |                              | 23                       | 3d. Date of deli<br>Month                           | very<br>Day Year                              |
| בל, ב       | w requires that<br>been signed b<br>should be deta   | b              | Part II. Other significant conditions   | contributing to        | death but no                   | ot resulting in the u                   | inderlying cause g                    | given in Part I.                            |                              | obacco us<br>Yes 2       |   | the cause of death?                           |
| necoras,    | e la<br>has<br>je 2  | Completed      |   |                        |                                |   |                                       |   | 24a. Was<br>auto<br>perfo    |                          | 24b. Were aur<br>prior to death?<br>1 \( \text{Yes} | opsy findings available ompletion of cause of |
| N ICA       | sician: Th<br>certificate<br>irector, pag  | Be             | 25. Was case referred to medical examiner?  |                        |                                |   |                                       | 26. Place of Dea                            | th (Check only               |                          |   |   |
| 5           | Physic<br>this ce<br>al dire   | 0              | 1 ☐ Yes 2 ☐ No  | Hospital: 1            | Inpatient                      | 2 ☐ ER/Outpatie                         | nt 3 DOA                              | ther: 4 🗌 Nursing H                         | ome 5 Resi                   | dence 6                  | <b>⊠</b> Other (Spec                                | masstd. liv                                   |
| =           | ding Ph<br>h.<br>After th<br>funeral   | on:            | 27. Manner of Death  S☐ Natural 5 ☐ Pending   | 28a. Date<br>(Moi      | of Injury<br>oth, Day Ye       | 28b. Time of Injury                     | W                                     | ork?  | 28d. Describe                | how injury               | occurred  |   |
| 2           | death.<br>ctor: A<br>y the fu  | catl           | 2 Accident investigat 3 Suicide 6 Could not   | bo                     |                                |   |                                       | □Yes 2□No                                   | 00/ 1 1' /                   |                          | A/combon on Co                                      | or / Courts Africa has                        |
|             | or fifter<br>Dire<br>in b  | Certification: | 4 Homicide determine  | d 286. Plac            | e of Injury -<br>ling, etc. (S | At home, farm, st<br>Specify)           | reet, factory, office                 | Э   |                              | Street and<br>wn, State) | vaniber of Mu                                       | ral Route Number,                             |
| -1          | Hospital<br>4 hours a<br>Funeral I<br>ely filled   | Medical Ce     |   | aminer: On the         |                                |   |                                       | time, date and place<br>opinion, death occu |                              |                          |   |   |
|             | To the within 2 To the complet   | Me             | 29b. Signature and title of certifier   |                        |                                |   | 29c. Lice                             | nse number                                  |                              | 29d. Date                | signed (Month                                       | n, Day, Year)                                 |
|             | P 5 P 0  |                | \$ (  | nuc                    |                                |   | De                                    | 0641  |                              | Jan                      | wary ?  | 2008  |
| )           | 00   |                | 30. Name and address of person whe Ramed Saleman  | o completed cau        | se of death                    | (Item 23a) (Type                        | Print)<br>Rivert Na                   | ck Road                                     | Baltimo                      | re h                     | lauy lan  | 1 2/22/                                       |
|             | Sta<br>Registi   |                | 31. Date filed (Month, Day, Year)   | 2008 32.               | Registrar's                    | Signature                               | berte                                 |   |                              |                          |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. UU8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Pauline M. Clark 2008 an /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HUnder 24 Hrs None 8. Date of Birth (Month, Day, Year) Sept 7, 19 If Under 1 Birthplace (State or Foreign Country) Security Number 6 Sex (In yrs. last birthday **Funeral** Days Months 1 ☐ M 2 🛛 F Yrs 1930 218 24 2525 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Show 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Baltimore MD Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 30 Laurence Brooke Road 21228 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after l ∏Yes 2**∑** No f Yes, Give ∕ear or Dates: 1 Never Married Married 1 ☐ Yes 2√2 No δ Specify: 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Commercial permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown unknown Starkey Mamie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert S. Clark/Husband 30 Laurence Brooke Rd Catonsville, MD 21228 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 2-2-2008 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 this 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 30min /Medical Due to (or as a consequence of) Examiner Myocar Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the burial-transit and Due to (or as a consequence of): physician for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t 9□Unknown cate has been signed, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Hunknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 1 Ho 24a. Was an 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Tyes 2 No 1 Inpatient 2 NER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🛫 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Division or Vital Records, P.O. Box 68760,

Maryland 21215-0036

altimore,

1m2

the

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

2008

29b. Signature and title of certifier

31. Date filed (Month

32. Begistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 22, 12:30 A.M Detweiler January 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 9,1962 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1X M 2 □ F 45 New Jersey 152-62-7820 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1XYes 2 No notified Penn. Huntingdon Huntingdon 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 0 be 301 Washington Street Unit 1 Front 16652 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examiner must I Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married <sub>Specify:</sub> White altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto/Construction Tradesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Joyce Kennedy John H. Detweiler 19b Mailing Address (Streehand Number of Flural Route Mumber, City or Town, State, Zip Code) 4,707 Chevy Chase Drive #3047ber, City or Town, State, Zip Code) Chevy Chase, MD 20815 19a. Informant's Name/Relationship (Type. Print) Patricia Kennedy/Sister 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition George Commission of the classification of the control of the classification of the classification of the control of the classification of the control of th 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. Medical 4X Donation 5 ☐ Other (Specify) Center 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Columbia Mortuary Services, P.A. 9013 Annapolis Road, Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hepatie /Medical Due to (or as a consequence of): **Examiner** cirrhosi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit ETOH Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No encepholopath Completed TWEILER JOHN 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? certificate 2X No funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of 27. Manyler of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident hin 24 hours after death the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō trifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the within 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0062 167 1/22103

State Registrar

31. Date filed (Month, Day, Year)

JAN 3 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



8600 Old Georgetown Road

Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month CO45 AM February Kay 08 08 /Medical Delauter 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 ☐ M 2 🖾 F 220-48-4903 Director Nov.9, 1950 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ∑Yes 2 No Director Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1547 Kensington Dr. 21742 Funeral U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married ☐Yes 2 No Yes, Give X Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Ice Cream Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howell Herbert Rohrer Ruth Lorraine Dayhoff any Injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ricky L. Delauter/Husband 10831 Waterworks Rd., Williamsport, MD 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 2/11/2008 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complication shock, or heart failure. List only on that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts.) Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2☐No 9□Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ☐ ER/Outpatient 3□ DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours fiter deall e Funeral Director 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mame and address of person completed eause of eath (Item 23a) (Type, Print) 11110 meda 31. Date filed (Month, Day, Registrar's Signature Year) State 2174 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|             |  |                  | T = State Registrar  | olale of Mary  |                                       | ertificate of  |                                |                                | Reg. No.                       | 08                              | 04152  |
|-------------|--|------------------|--|--|---------------------------------------|--|--------------------------------|--------------------------------|--------------------------------|---------------------------------|--|
| - C         | Physici  | an               | 1. Decedent's Name (First, Middle, Last)   |  |                                       |  |                                | 2. Date of Dea<br>Month        | Day                            | Year                            | 3. Time of Death                               |
|             | /Medic   | cal              | Helen F 4a. Facility Name (If not institution, give str  | easter   | Dent                                  | 4b. City. Town, o  | r Location of Death            | January                        | 24, 20<br>4c. County of        |                                 | 1:40 P. M                                      |
|             | Examin   | ier              | Wilson Health Care   |  |                                       | Gaithe   |                                |                                | Monte                          |                                 | ~v   |
| b           | Funeral  |                  | 5. Social Security Number 6. Sex   | 7. Age (In   | yrs. last birthda                     | Months   Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birt<br>(Month, Day | h                              |                                 | lace (State or Foreign                         |
|             | Director   |                  | 220-34-7399 Usual Residence of Decedent  | 1  | 01 Yrs.                               |  |                                | Dec. 12                        | 1906                           | N                               | D.   |
|             | ytand<br>ytand<br>at   |                  | 10a. State 10b. County   | 100  | c. City, Town or                      | Location   |                                |                                |                                | 1                               | 0d. Inside City Limits                         |
|             | e Mar<br>3a-f sl<br>tiffied  | ctor             | MD. Montgome   | ry   | Gaith                                 | ersburg  |                                |                                |                                |                                 | 1 X Yes 2 ☐ No                                 |
|             | vith th  | Dire             | 10e. Street and Number   |  |                                       | 10f. Zip Code  |                                |                                | 10g. Citizen of W              | hat Cour                        | itry?  |
|             | ns 23s   | Funeral Director | 301 Russell Avenue   | Was Decedent Ever  | in U.S.                               | 208<br>3. Was Decedent of H  |                                | pecify Yes or No-              | United<br>14. Race             |                                 | ates<br>an Indian,                             |
| ۵           | after d<br>or iten<br>niner  |                  | 1 Never Married 2 Married  | Armed Forces? 1 ☐ Yes 2X No If Yes, Give                         |                                       | 3. Was Decedent of H If Yes, specify Cuba                                  |                                | Rican, etc.)                   |                                | , White,                        |  |
| 215-0036    | hours after death with the Maryland<br>tural", or Items 23a or 28a-f show<br>al Examiner must be notified at   | d by             | 3X Widowed 4 □ Divorced  | Year or Dates:   |                                       | 1 ☐ Yes 2 <b>X</b> Î No  | Specify:                       |                                | Specify:                       |                                 | ite  |
| Σ.          | n 72 ł<br>i "nati<br>edica   | Completed        | 15. Decedent's Educa<br>(Specify only highest grade of   | ompleted)  | (Gi                                   | cedent's Usual Occup<br>ive kind of work done on<br>the DO NOT use retired | during most of work            | king                           | 16b. Kind of Bus               | siness/Ind                      | dustry   |
| 717         | filed within 72<br>Hygiene.<br>Ither than "nai<br>Ithe Medica  | mo.              | Elementary/Secondary (0-12)  | College (1-4or 5+)   |                                       | omemaker   | -,                             |                                | Home                           | <u>.</u>                        |  |
| land        | 0 20 0   | Bec              | 17. Father's Name (First, Middle, Last)  |  |                                       |  | 18. Mother's Nam               | e (First, Middle,              | Maiden Surname                 | 9)                              |  |
| <u>ya</u>   | ould be<br>Menta<br>narked<br>natic ev   | 2                |  |  | aster                                 |  |                                | Cora                           | Culler                         |                                 |  |
| <u>a</u>    | d 2 sh<br>th and<br>th sn<br>?7 is n<br>traum  |                  | 19a. Informant's Name/Relationship (Type   | ,  |                                       | Claha Maa  |                                |                                |                                |                                 |  |
|             | s 1 an<br>f Heal<br>item 2<br>other  |                  | Georgia Dent DiPietr 20a. Method of Disposition  | 2  | 0b. Place of Dis                      | Glebe Mea  | i                              | Date                           | 20c. Location - C              |                                 |  |
| <u> </u>    | Page<br>nent o<br>ant: if<br>ury or  |                  | 1X Burial 2 ☐ Cremation 3 ☐ Rer<br>4 ☐ Donation 5 ☐ Other (Specify)  |  | ,,                                    | 's Cemeter   | í                              | /2008                          | Jefferso:                      | n. M                            | arvland  |
| gaitimore,  | permit. Pages 1 and 2 should be Department of Health and Ments Important: If Item 27 is marked any Injury or other traumatic enonce.                             |                  | 21. Signature of Funeral Service Licensee  | 000  |                                       | 22. Name and Addre   | ss of Facility De              | Vol Fund                       | eral Hom                       | e                               |  |
|             |  | _                | 20g Bort 1 Enter the diseases or complian  | Villed Consideration   |                                       | O East Dee   |                                |                                |                                | g, M                            | D. 20877 Approximate                           |
|             | Dhusisian  |                  | 23a. Part1. Enter the disease, or complica<br>shock, or heart failure. List only one<br>Immediate Cause (Final |  |                                       |  | ig, sucii as caidiac           | or respiratory ai              | rest,                          | 1                               | Interval Between<br>Onset and Death            |
|             | Physician<br>/Medical  |                  | disease or condition resulting in death)   | Concestive  Due to (or as a co                                   |                                       | Failure  |                                |                                |                                |                                 | l Day  |
|             | Examiner   |                  | Sequentially list conditions b.  | Coronary A   |                                       | isease   |                                |                                |                                |                                 |  |
|             | ed<br>sit  | Examiner         | Sequentially list conditions, if any, baung to mineral cause. Enter Underlying Cause (Disease or injury        | Due to (or as a no   | nsequenne of):                        |  |                                |                                |                                |                                 |  |
|             | execut<br>n and<br>al-tran   | xan              | that initiated events c resulting in death) Last   | Due to (or as a co   | nsequence of):                        |  |                                |                                | <del></del>                    |                                 |  |
| 58/50,      | tificate be executed<br>ig physician and<br>as the burial-transit  | ledical I        | d.   |  |                                       |  |                                |                                |                                |                                 |  |
|             | ertifica<br>ing ph   | Medi             | IF FEMALE:   |  |                                       |  |                                |                                |                                | _                               |  |
| X<br>Q<br>Q | sician: The law requires that the death cer certificate has been signed by the attendin rector, page 2 should be detached for use                                | Physician/N      | 23b. Was decedent pregnant in the past 12 months?  | . If yes, outcome pf pi<br>1□Live birth 2□<br>4□Pregnant at time | Fetal death                           | 3 □Ectopic pregnancy<br>5 □ Other (specify) _                              | у                              |                                | 23d. Date<br>Mon               |                                 | ery<br>Day Year                                |
| į           | the de   | hysic            | 1 ☐ Yes 21 <b>∑</b> No<br>9 ☐ Unknown  | 9□Unknown  | Ordeall                               | Old Other (apeciny) _  |                                |                                | i                              |                                 |  |
| ν,<br>T     | requires that the<br>een signed by the<br>hould be detache   | by Pl            | Part II. Other significant conditions contri   |  |                                       |  | en in Part I.                  | 23e. Did to                    | obacco use contri              | bute to th                      | ne cause of death?                             |
| סום         | require<br>sen si  | ted              | Atrial Fibrillation  | , Hyperten   | sion, A                               | nemia  |                                | 1 🗆 1                          | res 2 🔀 No                     | 3 ☐ Prot                        | ably 4 Unknown                                 |
| Records,    | e law<br>has by<br>je 2 st   | Completed        |  |  |                                       |  |                                | 24a. Was<br>autop              | osv İ pı                       | ere auto<br>rior to co<br>eath? | psy findings available<br>mpletion of cause of |
| VIIal       | in: The<br>fficate ha  | e Co             | 25. Was case referred to medical   |  | · · · · · · · · · · · · · · · · · · · |  | 00 Discout December            | 1∐ Yes                         | 2 🔀 No 1                       | Yes                             | 2 No   |
| 5           | Physician:<br>this certific  | O B              | examiner?  | pitał: 1 ☐ Inpatient   | 2 ER/Outpat                           | ient 3 DOA Oth   | 26. Place of Dea               |                                | <i>ine)</i><br>dence 6 □Othe   | r (Specif                       | v)   |
| 0           | ng Ph<br>fter thi  | n: T             | 27. Manner of Death 1 X Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Ye                            | 28b. Time                             |  | ry at                          |                                | now injury occurre             |                                 |  |
| JIVISION    | Attending r death. ector: After by the fune  | catic            | 2 Accident investigation 3 Suicide 6 Could not be  | One Disea of injury  | At home form                          |  | Yes 2 □ No                     | 206 1                          | 34 181                         |                                 |  |
| 2           | after d<br>Direction by  | Certification:   | 4 ☐ Homicide determined  | 28e. Place of injury -<br>building, etc. (S                      | pecify)                               | street, ractory, office  |                                | City or Tox                    | Street and Numbe<br>vn, State) | r or Hura                       | ir Houte Number,                               |
|             | ospita<br>hours<br>uneral<br>ly filler   |                  | 29a. Certifier  1  Certifying Physic  (Check only  2 ☐ Medical Examine   | ian: To the best of my   | y knowledge, de                       | eath occurred at the til   | me, date and place             | , and due to the               | cause(s) and mar               | nner as s                       | tated.   |
|             | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director, | Medical          | one)   | and manner stated.   | nadon and/or                          | 29c. Licens  |                                |                                |                                |                                 |  |
|             |  |                  | 29b. Signature and title of certifier  | 3, , 1   | . ( ~                                 | .  |                                |                                | 29d. Date signed               |                                 | *        |
| ,           | (0   |                  | 30. Name and address of person who com   |  | 1                                     |  | 4115                           |                                | · mue                          | 7                               | 24,2008  |
|             |  | J)               | H. Robert Birschbach   | , M.D., 20   | 01 Russ                               |  | , Gaither                      |                                |                                |                                 |  |
|             | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year)  JAN 3 0 200   | 32. Registrar's  | Signature                             | books  |                                |                                |                                |                                 |  |
|             |  |                  | 01111 0 0 1.00   |  | 10                                    |  |                                |                                |                                |                                 |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** JANUARY 25,2008 /Medical RHONA WEINRACH ELLIS 4c. County of Death 4b. City, Town, or Location of Death Examiner National Institute of Health Montgomery Bethesda 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) March 13, 1951 PhiladelphiaPA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7 Age (In vrs. last hirthday) **Funeral** Months Days Hours 1 M 2 F 138-42-2128 56 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural"; or items 23a or 28a-f show any fluly or other traumatic event, the Medical Examiner must be accounted. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County PA. Cumber land Mechanicsburg 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 518 Allenview Drive 17055 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Research Technician Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Bagel Melvin Weinrach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 518 Allenview Dr., Mechanicsburg, PA 17055 / spouse John Ellis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 📉 Removal from State Jan. 27, 2008 Abbington, PA Montefiore Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Fund al S vice License 254 Carroll St., NW, Washington, DC 20012 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final **Physician** LYMPHOMATOID 3Months GRANULOMATOSIS disease or condition resulting in death) /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner and -tran Due to (or as a consequence of) physician ar Division or Vital Records, P.O. Box 68760. The law requires that the death certificate be Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) the 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death 1 Matural 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗹 certifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Hean W. Meadour M.D. D63305 JANUARY 25, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

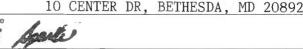
Registrar

31. Date filed (Month, Day, Year)

JAN 29

MEADOWS, M.D.

32 Registrar's Signature
2008



1 - For State Registrar

| B1   |                | 1. Decedent's Name  | (First, Middle, Las              | t)                                 |                                    |                                 |                                    |                                   |                            | 2. Date of D<br>Month          | eath<br>Day                 | Year                     |  | e of Death                   |
|--|----------------|---|----------------------------------|------------------------------------|------------------------------------|---------------------------------|------------------------------------|-----------------------------------|----------------------------|--------------------------------|-----------------------------|--------------------------|--|------------------------------|
| Physic<br>/Med   | 84             | MARY A  | LLEN ENG                         | LE                                 |                                    |                                 |                                    |                                   |                            | JANUA                          | ARY 27                      | 7 2008                   | 3 2:1  | LO AM                        |
| Exami  | Marine Co.     | 4a. Facility Name (If I   | not institution, give            | street and nur                     | mber)                              |                                 | 4b. City, Tow                      | n, or Locatio                     | n of Death                 |                                | 4c. Co                      | ounty of De              | ath  |                              |
| 145  | 8              |   | ANTERBURY                        |                                    | "                                  | (- 4 b ! Ab d- 1)               |                                    | STON                              | er 24 Hrs.                 | R Data of B                    | Pieth                       | TALBO                    | <b>)T</b><br>irthplace (Sta                          | to or Foreign                |
| Funeral  |                | 5. Social Security Nu   | 1                                | ex<br>□M 2【 <b>X</b> F             | 7. Age ( <i>In yrs</i> . <b>86</b> | last birthday)<br>Yrs.          |                                    | ays Hours                         |                            | 8. Date of B                   | Day, Year)                  |                          | irinpiace (Sia<br>Co <i>untry)</i><br><b>T.AHOMA</b> | _                            |
| Director   |                | 455-14-15<br>Usual Residence of I   |                                  |                                    | 00                                 |                                 |                                    |                                   |                            | JAN Z                          | 6, 192                      | ZUN                      | LAHOPA   |                              |
| /land<br>ow  |                |   | 10b. County                      |                                    | 10c. Cit                           | y, Town or Lo                   | ocation                            |                                   |                            |                                | -                           |                          |  | City Limits                  |
| Many<br>1-f sh<br>fied   | ţ              | MD  | TALBO                            | T                                  |                                    | EASTO                           | 7                                  |                                   |                            |                                |                             |                          | 1 🗆 \  | es 2 XNo                     |
| h the  | Director       | 10e. Street and Num   | ber                              |                                    |                                    |                                 | 10f. Zip Co                        | de                                |                            |                                | 10g. Citize                 | n of What (              | Country?   |                              |
| th wit<br>23a o<br>Ist be  | a<br>D         | 28163 CA  | NTERBURY                         | COURT                              |                                    |                                 | 2                                  | 1601                              |                            |                                |                             | USA                      |  |                              |
| r dea<br>ems<br>er mu  | Funeral        | 11. Marital Status  |                                  | Armed Fo                           |                                    | .S. 13.                         | Was Decedent<br>If Yes, specify    | of Hispanic (<br>Cuban, Mexic     | Origin? (Sp<br>can, Puerto | ecify Yes or N<br>Rican, etc.) | No- 14                      | . Race - An<br>Black, Wh | nerican Indian<br>nite, etc.                         | 3                            |
| s afte   | by Fi          | 1 ☐ Never Marrie 3 📆 Widowed 4  |                                  | 1 ∐Yes<br>If Yes, Giv<br>Year or D | ve                                 |                                 | 1 □ Yes 2                          | No Speci                          | ty:                        |                                | S                           | pecify:                  | HITE   |                              |
| IIIU Z I Z I 3-0030 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at |                |   | 15. Decedent's Ed                |                                    | ates.                              | 16a. Dece                       | dent's Usual O                     | ccupation                         |                            |                                | 16b. Kind                   | of Busines               |  |                              |
| in 72<br>in 72<br>in 72  | Completed      | (Special  | fy only highest gra              | de completed)                      | I 4== 5 · \                        | (Give                           | kind of work a<br>DO NOT use n     | one during m                      | ost of work                | king                           |                             |                          |  |                              |
| iene.  | E O            | Elementary/Secon  | idary (0-12)                     | College (*                         |                                    | PH                              | YSICIAN                            |                                   |                            |                                | PEDIA                       | TRIC                     | CARDIC   | LOGIST                       |
| - 0 - 0 5  | Be C           | 17. Father's Name (   | First, Middle, Last)             |                                    |                                    |                                 |                                    |                                   |                            | e (First, Midd                 |                             | urname)                  |  |                              |
| the should be not marked matic even  | F E            | RUSSELL   | COLOMBUS                         | ENGLIS                             | SH                                 |                                 |                                    | VI                                | RA Al                      | PPERSON                        | 1                           |                          |  |                              |
| re, Mal yla  |                | 19a. Informant's Na   | me/Relationship (                | Type. Print)                       |                                    |                                 | ng Address (Si                     |                                   |                            |                                |                             |                          | , Zip Code)  |                              |
| and and and and and and and and and and  |                |   | E. ENGLI                         | Z/DAUGH                            |                                    |                                 | GROVE                              |                                   | LEXA                       |                                |                             |                          | T Ct-t   |                              |
| ) 0 0 <del></del>  |                | 20a. Method of Dispo  | osition<br>Cremation 3           | Removal from                       | State 20b.                         | Place of Displ<br>cemetery, cre | osition (Name of<br>matory or othe | r place)                          | ·<br>·                     | Date                           |                             | -                        | or Town, State                                       |                              |
| Pag<br>ment<br>tant: I   | Ι.,            | 4 ☐ Donation  | 5 Other (Specif                  | y)                                 | СН                                 | 100                             | KE CREM                            |                                   |                            |                                |                             |                          |  |                              |
| Dallillo<br>permit. Pages<br>Department of<br>Important: If i<br>any injury or once.   |                | 21. Signature of Fur  | neral Service Licer              | isee                               | CFS                                | $\rho$ $\mathbf{F}$             | 2. Name and A<br>ELLOWS ,          | HELFI                             | NBET                       | N & NEW                        | MAM F                       | JNERAI                   | L HOME   | PA                           |
|  |                | M.E.  | Newya                            | M                                  | C T J                              | th Do not on                    | 00 S. I                            | IARRISO                           | ON ST                      | EASTON                         | MD 2                        | 21601                    | Approxi  | mate                         |
|  | 10.            | 23a. Part1. Enter the<br>shock, or hear   |                                  | one cause in a                     | each line.                         | E O                             | ter the mode o                     | /                                 | as cardiac                 | orrespiratory                  | anest                       |                          | Interval   | Between<br>and Death         |
| Physician  |                | Immediate Cause (F<br>disease or condition<br>resulting in death)   | -inai<br>i                       | .a. 10                             | reas                               | 1 4                             | ween                               |                                   |                            |                                |                             |                          | 100  | /KS.                         |
| /Medical<br>Examiner   |                | ,   |                                  | Due to                             | (or as a consec                    | quence of):                     |                                    |                                   |                            |                                |                             |                          |  |                              |
|  | jo l           | Sequentially list con   | ditions,                         | b                                  | (or as a consec                    | quence of):                     |                                    |                                   |                            |                                |                             |                          |  |                              |
| rted<br>nsit   | Examiner       | Sequentially list con if any, leading to important the cause. Little Under Cause (Disease or ithat initiated events | njury                            |                                    |                                    |                                 |                                    |                                   |                            |                                |                             |                          |  |                              |
| execu<br>n and<br>al-tra   | Exal           | resulting in death) L   | ast                              | c<br>Due to                        | (or as a consec                    | quence of):                     |                                    |                                   |                            |                                |                             |                          |  |                              |
| ficate be ex<br>physician is the burial  |                |   |                                  | _d                                 |                                    |                                 |                                    |                                   |                            |                                |                             |                          |  |                              |
| BOX 06/00,<br>eath certificate be executed<br>attending physician and<br>for use as the burial-transit   | cian/Medical   | _   |                                  |                                    | -                                  |                                 |                                    |                                   | -                          |                                |                             |                          |  | -                            |
| BOX<br>ath cer<br>attendir<br>for use  | an/N           | IF FEMALE:<br>  23b. Was decedent   |                                  | 23c. If yes, ou<br>1□Live          | tcome pf pregn<br>birth 2 □ Fet    | ancy<br>al death 3              | □Ectopic preg                      | палсу                             |                            |                                | 23                          | d. Date of o             | delivery<br>Day                                      | Year                         |
| death<br>he atten  |                | in the past 12<br>1 ☐ Yes 2 ☐   | 7                                | 4□Preg<br>9□Unkn                   | nant at time of                    | death 5                         | Other (speci                       |                                   |                            |                                | -                           | WOTH                     | Day  | i eai                        |
| cords, F.C. w requires that the d been signed by the should be detached  | Physi          | 9 ☐ Unknown   |                                  |                                    |                                    |                                 |                                    | iven in De                        | and I                      | 220 Di                         | id tobacco us               | o contribute             | e to the cause                                       | of death?                    |
| S, I<br>es thi<br>igned<br>be de   | by             | Part II. Other signifi  | icant conditions                 | contributing to d                  | leath but not res                  | sulting in the                  | underlying caus                    | se given in Pa                    | art I.                     |                                | □ Yes 2□                    |                          |  | Unknown                      |
| COTGS, w requires t been signe should be c   |                |   |                                  | <u> </u>                           |                                    |                                 |                                    |                                   |                            | ''                             |                             |                          |  |                              |
| law ras be   | ple            |   |                                  |                                    |                                    |                                 |                                    |                                   |                            | 24a. W                         | topsy                       | prior                    | autopsy findi<br>to completion                       | ngs available<br>of cause of |
| VITAI HEC<br>sician: The law<br>certificate has t<br>irector, page 2 s   | Completed      |   |                                  |                                    |                                    |                                 |                                    |                                   |                            | 1□ Yes                         | erformed?<br>s 2 No         | death<br>1 🗆 Y           | es 2□No  |                              |
| VITAI<br>ician: T<br>certificat<br>ector, pi   | Be             | 25. Was case referrexaminer?  | red to medical                   | Hospital:                          |                                    |                                 |                                    | T                                 |                            | th Check onl                   |                             |                          |  |                              |
| <u> &gt; .</u> ≥ p   | 2              | 1 Yes 25  |                                  | <u>' '</u> '                       | Inpatient 2                        | ER/Outpatie                     |                                    | 4 L                               | Nursing H                  | lome 5 Re                      | esidence 6<br>be how injury |                          | ipecify)   |                              |
| - 0 0  | in oi          | 27. Manner of Death   | 5 Pending                        | ,                                  | nth, Day Year)                     | Injury                          | M 200                              | . Injury at<br>Work?<br>1 ☐ Yes 2 | P□No                       | 200. Describ                   | oc now injury               | occanica                 |  |                              |
| SIC<br>Item<br>Heath<br>Heath<br>Stor:   | cat            | 2 ☐ Accident<br>3 ☐ Suicide   | investigatio<br>6  ☐ Could not b | e 28e Plac                         | e of injury - At h                 | nome, farm, s                   |                                    |                                   |                            | 28f. Location                  | n (Street and               | Number or                | Rural Route  | Number,                      |
| DIVISION  I or Attending after death. Director: Afte   | Certification: | 4 ☐ Homicide  | determined                       | build                              | ling, etc. (Spec                   | ify)                            |                                    |                                   |                            | City or                        | Town, State)                |                          |  |                              |
| DIVISION  To the Hospital or Attention  within 24 hours after death  To the Funeral Director:  completely filled in by the   |                | 29a. Certifier  | Certifying Pl                    | hysician: To th                    | e best of my kn                    | iowledge, dea                   | th occurred at                     | the time, date                    | e and place                | e, and due to t                | the cause(s)                | and manner               | r as stated.   |                              |
| e Hos<br>24 h<br>e Fur<br>letely   | Medical        | (Check only one)  | 2☐ Medical Exa                   | miner: On the                      | basis of examin<br>nner stated.    | ation and/or                    | investigation, ir                  | my opinion,                       | death occi                 | urred at the tin               | ne, date and                | place, and               | due to the car                                       | use(s)                       |
| <b>Го th</b><br>within<br><b>Го th</b><br>сотр   | Me             | 29b. Signature and  | title of certifier               | 7                                  |                                    | _                               | 29c. L                             | icense numb                       | er                         |                                | 29d. Date                   | signed (M                | onth, Day, Ye  | ar)                          |
| )  |                | > 17h   | Wa X                             | MM                                 |                                    |                                 |                                    | 139                               | 887                        |                                | 11                          | 281                      | 108  |                              |
| 15   |                | 30. Name and addr   |                                  |                                    |                                    |                                 |                                    |                                   | - 1                        |                                | - (                         | ,/                       |  |                              |
| 15   |                | DAVID S   | MITH, M.                         |                                    |                                    | _                               | JITE 30                            | 2, EAS                            | TON,                       | MD 216                         | 01                          |                          |  |                              |
|  | tate           | 31. Date filed (Mon   |                                  |                                    | Registrar's Sigr                   |                                 |                                    |                                   |                            |                                |                             |                          |  |                              |
| Regis  | strar          | J   | AN 2 9 20                        | JUB M                              | eve !                              | K A                             | and s                              |                                   |                            |                                |                             |                          |  |                              |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 0 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year **Physician** 12:42a Magdalene Long Forsythe 28,2008 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Friends Nursing Home Sandy Spring Montgomery 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Year | If Under 24 h 5. Social Security Number If Under 1 Birthplace (State or Foreign Country) **Funeral** Days Hours 327-01-7262 1 M 2 F 89 Yrs Director Jan. 4, 1919 Kentucky Usual Residence of Decedent or 28a-f show a notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 14605 Sandy Ridge Road 20905 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: White <u>۾</u> 3 K Widowed 4 □ Divorced Completed or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nurse Medical other i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h Uri Lee Long Eva Russell Eakins P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra Patricia F. Campbell/Daughter 14605 Sandy Ridge Road, Silver Spring, MD 20905 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 2, ™XBurial 2 ☐ Cremation 3 K Removal from State Feb. Mt. Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Wilmington, IL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility whard I Males Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular Accident /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine y physician and as the burial-trans Hypertension resulting in death) Last Due to (or as a consequence of) Physician/Medical attending pl for use as t IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No detached for Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has funeral director, page 2 autopsy performed? res 2 170 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 🗶 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2€XNo Certification: To 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a, Certifie 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

To the Hospital or

The law requires that the death certificate be executed

Attending Physician:

Division or Vital Records. P.O. Box 68760.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

Ramani B. Reddy, MD 31. Date filed (Month, Day, Year) JAN 2 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13975 Connecticut Avenue, #202, Silver Spring, MD 20902 egistrar's Signature

D0060089

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 12:50 PM LINN GRET FEBRUARY 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL GLEN Medical Center BURNIE BAHIMORE WAShington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 214-62-0991 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🕶 F Months Days Hours Min. Director 1-21-54 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatith and Mential Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23e or 28e-4 ahov any Injury or other traumatic awant, It a Middeal Examiner must be notified at 1 Yes 2 No Director ANNEHRUNDE 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced INITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JE MD. 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ACENT CREMATORY 3
22. Name and Address & Facility 4 ☐ Donation 5 ☐ Other (Specify) Service Lice of of F Pasadena, MD 21122-1215 21. Signatu Daugherty Family Funeral ZCC MCCNTAIN RD. esed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ero, 4vgr disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner mial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1686 Yes 2 No 3 Probably 4 Unknown 10 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No sout was 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation filled in by the within 24 hours after deat To the Funerel Director: 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ひらろとい 02,04,2008 30. Name and address of person who concleted cause of death (Item 23a) (Type, Print) MA DE COD NAM YOU MATI 301 HO>8 DRIVE CITEM BURNIE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

2008

| Physicia   |  | <ol> <li>Decedent's Name (First, Middle, Las</li> </ol>   | t)   |  |  |   |   |                                     | of Death   |  |  | 3. Time of E   |
|--|--|---|--|--|--|---|---|-------------------------------------|--|--|--|--|
| /Medic   |  | LEROY   | GRAHAM   |  |  |   | · .   | Mod                                 | . W  | P6,  | 2008   | 1755   |
| Examin   | and the                                  | 4a. Facility Name (If not institution, give PRINCE GEORGE S   |  |  |  | y, Town, or L<br>HEVERI   | ocation of Dea  | ath                                 |  |  | y of Death<br>CE GE(   | ORGE'S   |
| uneral<br>irector  |  | 249-50-8313   | 7. Age (i<br>M 2□ F  | In yrs. last birthd<br>77 Yrs  | Months   |   | If Under 24 Hi<br>Hours Mii   | n. (Mol                             | of Birth<br>oth, Day, Ye   | ear)<br>1930   | Coun   | lace (State or<br>htry)<br>H CAROI   |
| f show   |  | Usual Residence of Decedent  10a. State 10b. County DC  |  | 0c. City, Town or  |  |   |   |                                     |  |  | 1  | 0d. Inside City  |
| a or 28a<br>t be notif   | Direc                                    | 10e. Street and Number<br>5040 D ST., S.E.  | . #10  |  |  | Zip Code  |   |                                     |  |  | What Cour  |  |
| Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Fur                                   | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | 12. Was Decedent Eve<br>Armed Forces?<br>Yamed Forces?<br>Yamed Forces?<br>Yamed Forces<br>Yes, Give<br>Year or Dates:   | er in U.S.   | 13. Was Dec<br>If Yes, sp  |   | panic Origin?<br>, Mexican, Pue<br>Specify:   | (Specify Yes<br>erto Rican, e       |  | 14. Ra<br>Bla  | ce - Americack, White,   | ean Indian,<br>etc.  |
| in "natur<br>Medical I   | Completed                                | 15. Decedent's Ed<br>(Specify only highest gra-   | ucation<br>de completed)<br>College (1-4or 5+)   | (G   | ecedent's Us<br>Give kind of w<br>fe. DO NOT   | sual Occupat<br>vork done du<br>use retired)  | ion<br>ring most of w   | orking                              | 168  | . Kind of I  | Business/Ind   | dustry   |
| the tha  | mo.                                      | Elementary/Secondary (0-12)<br>12th   | College (1-401 5+)   |  |  | r   | RUCK D  | RIVER                               |  | ruck   | ING  |  |
| narked othe  | To Be (                                  | 17. Father's Name (First, Middle, Last)  JAMES GRAHAM   |  |  |  |   | 8. Mother's N<br>ELIZAB   |                                     |  | den Surna  | me)  |  |
| s mar<br>umat  | -  | 19a. Informant's Name/Relationship (7   | ype. Print)  | 19b. M   | ailing Addre   | ss (Street an   | nd Number or i  | Rural Route                         | Number, C  | ity or Towi  | n, State, Zip  | Code)  |
| n 27 i<br>ier tra  |  | CHARLENE BROOKS   |  | 5040   | D ST   | ., S.E  | E. #10  |                                     |  |  |  |  |
| nt: If Iter<br>ry or oth   |  | 20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify   | Removal from State   | 20b. Place of Di<br>cemetery,<br>CHESAPEA  | crematory oi   | r otner piace,  |   | Date<br>3/08                        |  |  | - City or To   |  |
| Importa<br>any Inju<br>once.   |  | 21. Signature Funeral Service Unen  | see  | 200  |  | and Address   |   | 1 405                               |  |  |  | DC 20  |
| miner  |  | resulting in death)   | Due to (or as a c  |  | RHYTH  | MIA   |   |                                     |  |  |  |  |
|  | al Examiner                              | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | u  | consequence of):   | 0  | MIA   |   |                                     |  |  |  |  |
| g physician and<br>as the burial-transit   | hysician/Medical Examiner                | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b. Due to (or as a c   | consequence of: consequence of: consequence of:  | 0  | pregnancy   |   |                                     |  |  | ate of delive  | ery<br>Day Ye  |
| igned by the attending physician and<br>be detached for use as the burial-transit  | 5  | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No                                    | Due to (or as a c  Due to (or as a c  Due to (or as a c  d.  23c. If yes, outcome pf 1 □ Live birth 2 [ 4 □ Pregnant at tin 9 □ Unknown  | consequence of): consequence of): pregnancy Fetal death ne of death  | 3 ⊟Ectopic<br>5 ⊡ Other (  | pregnancy<br>specify)   | in Part I.  | 236                                 |  | co use cor   | lonth<br>ntribute to th  | -  |
| been signed by the attending physician and hould be detached for use as the burial-transit   | þ  | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Due to (or as a c  Due to (or as a c  Due to (or as a c  d.  23c. If yes, outcome pf 1 □ Live birth 2 [ 4 □ Pregnant at tin 9 □ Unknown  | consequence of): consequence of): pregnancy Fetal death ne of death  | 3 □Ectopic<br>5 □ Other (  | pregnancy<br>specify)   | in Part i.  | 248                                 |  | co use coi   | ntribute to the  | Day Ye ne cause of de pably 4 XUr psy findings a mpletion of cau   |
| ertificate has been signed by the attending physician and sclor, page 2 should be detached for use as the burial-transit   | Be Completed by                          | Sequentially list conditions, cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1                         | Due to (or as a complete to for a complete to fo | consequence of): consequence of): pregnancy Fetal death ne of death  | 3 □Ectopic<br>5 □ Other (  | pregnancy<br>specify)<br>cause given  | 26. Place of D  | 24a                                 | 1 ☐ Yes  a. Was an autopsy performed Yes 2 ☑ conly one)  | co use coi 2 No 24b  | ntribute to the sum of | Day Year one cause of department of the past of the pa |
| After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit                      | To Be Completed by                       | Sequentially list conditions, cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1                         | Due to (or as a complete to for a | consequence of): consequence of): consequence of): pregnancy Fetal death ne of death not resulting in th   | 3 □Ectopic 5 □ Other (a second ry le of ry   | pregnancy<br>specify)<br>cause given<br>OOA Other<br>28c. Injury a  | 26. Place of D<br>:<br>4  Nursing<br>at   | 24a 1□ eath (Check                  | 1 ☐ Yes  a. Was an autopsy performed Yes 2 ☑ conly one)  | co use coi 2 No 24b  | ntribute to the sum of | Day Year one cause of department of the past of the pa |
| After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit                      | To Be Completed by                       | Sequentially list conditions, cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1                         | Due to (or as a complete to for a complete to fo | consequence of): consequence of): consequence of): pregnancy Fetal death ne of death not resulting in th  2  ER/Outpa  2  Sb. Tim Inju - At home, farm,  | 3 □Ectopic 5 □ Other (: te underlying  attient 3 □ □ te of ry  M   | pregnancy specify)    cause given   | 26. Place of D  | eath (Check Home 5 [ 28d. De:       | 1 Yes  a. Was an autopsy performed Yes 2 X (only one)  Residence scribe how in the control of th | Co use coil  2 No  24b  No  e 6 00  njury occurrent and Num                | Intribute to the stribute to t | Day Year one cause of department of the past of the pa |
| After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit                      | Certification: To Be Completed by        | Sequentially list conditions, cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | Due to (or as a complete to for a co | consequence of): conseq | 3 Ectopic 5 Other (  | pregnancy specify)  cause given  Constitution of the constitution | 26. Place of D  4 ☐ Nursing at at PS 2 ☐ No   | eath (Check<br>Home 5 [<br>28d. De: | 1 Yes  a. Was an autopsy performed types 2 X (only one)  Residence scribe how in the control of  | Co use coil  2 No  24b  37  No  e 6 00  injury occultand Numitate)         | Intribute to the stribute to t | Day Ye ne cause of de pably 4 XUr ppsy findings ampletion of cau 2 XNo   |
| this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit                                | edical Certification: To Be Completed by | Sequentially list conditions, and the cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1                 | Due to (or as a complete to for a compl | consequence of): conseq | 3 Ectopic 5 Other ( tient 3 Ee of ry M , street, factor leath occurre or investigation   | pregnancy specify)  cause given  Constitution of the constitution | 26. Place of D  4 \( \text{Nursing} \) at  as 2 \( \text{No} \) b, date and planion, death oc       | eath (Check<br>Home 5 [<br>28d. De: | a. Was an autopsy performer Yes 2 ☑ conly one)  Residence scribe how in the cause time, date   | No co use coi 2 No 24b d? No could not not not not not not not not not not | Intribute to the stribute to t | Day Ye ne cause of de pably 4 XUr appy findings a mpletion of cau 2 XNo  |
| After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit                      | edical Certification: To Be Completed by | Sequentially list conditions, cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1                         | Due to (or as a complete to for a compl | consequence of): consequence of): consequence of): consequence of): pregnancy Fetal death ne of death not resulting in th  2 ER/Outpa  28b. Tim Inju - At home, farm, (Specify)  my knowledge, d amination and/od.   | 3 Ectopic 5 Other ( 5 Other ( strient 3 E e of ry M, street, factor investigation of the contract of the | pregnancy specify)  cause given  COOA Other  28c. Injury a Work? 1 □ Ye  Cory, office  ad at the time on, in my opi   | 26. Place of D  4 \( \text{Nursing} \) at  as 2 \( \text{No} \) b, date and planion, death ocnumber | eath (Check<br>Home 5 [<br>28d. De: | a. Was an autopsy performed Yes 2 € (conly one)  Residence scribe how in automation (Street or Town, Street o  | No co use coi 2 No 24b d? No could not not not not not not not not not not | Intribute to the stribute to condeath?  I were autoprior to condeath?  I were stributed to condeath?  I were stributed to the stri | Day Ye ne cause of de pably 4 XUr appy findings a mpletion of cau 2 XNo  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician MORRIS GARNICK 27, 7:45 JANUARY 2008 Α /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY 15100 INTERLACHEN DRIVE #1017 SILVER SPRING f Under 1 Year | If Under 24 Hrs. | 8, Date of Birth (Month, Day, Year Of 17/1921 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** NEW YORK 1 ☑ M 2 ☐ F 86 052-16-5204 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Directo MARYLAND MONTGOMERY SILVER SPRING 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 15100 INTERLACHEN DRIVE #1017 20906 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify. Specify: ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTING CERTIFIED PUBLIC ACCOUNTANT 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TOBA SILBERSTEIN SAMUEL GARNICK ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type. Print) 15100 INTERLACHEN DRIVE #1017, SILVER SPRING, MD SELMA GARNICK - WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State JUDEAN MEMORIAL GDNS 01/30/2008 4 ☐ Donation 5 ☐ Other (Specify) OLNEY, MARYLAND 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC 21. Signature of Funeral EDWARD SAGEL FUNERAL DIRECT 1091 ROCKVILLE PIKE, ROCKVI

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Approximate Interval Between Onset and Death immediate Cause (Final disease or condition 10 MINUTES **Physician** MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, pequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examine the death certificate be executed ician and burial-tran Due to (or as a consequence of): ettending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No Division or Vital Records, P.O. 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? has page 2 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1X Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

31. Date filed (Month, Day, Year)

29b. Signature and fittle of cel

30 2008 JAN

Hifie



MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

DZ1340

29d. Date signed (Month, Day, Year)

JANUARY 28, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dorothy Grinchis January 26, 2008 6:55 A™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marian Assisted Living Brookeville Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, **Funeral** Days Year Hours 1 □ M 2 🗶 F Apr. 20, 1921 Director 154-10-8885 86 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show r 28a-f show notified at 1 ☐ Yes 2 X No Director MDBrookeville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be USA 20833 19109 Georgia Avenue #103 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 ♥ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important; If item 27 Is marked other any Injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph A. Goss, Sr. Josephine Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2009 Carter Mill Way Brookeville, MD 20833 Karen Gerken/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | 01/29/08 Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) estive **Physician** ong month /Medical Due to (or as a onsequence of): 6 month **Examiner** ronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) or Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy for Month Day 4☐Pregnant at time of death 5 Other (specify) the detached 9□ Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 2X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Tes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify)/ Certification: To 27. Manner of Ceath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31 Date filed (Month

aron

oder

29c. License number

29d. Date signed (Month, Day, Year)

| 08-01078         |
|------------------|
| Vincent Graybeal |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 - 04160 State of Maryland / Department of Health and Mental Hygiene

| 20   20   20   20   20   20   20   20  |  |  |  |  |  |
|--|--|--|--|--|--|
| The proper prope | Month Day Year                           |  |  |  |  |
| Upper Chesapeake Medical Center   Hardroot   |  |  |  |  |  |
| 219-40-3996   Xi M 2   P   64   Yrs   Mornins   Days   Mor.   Feb. 18, 1943   Co.  |  |  |  |  |  |
| Usual Residence December  100, 1910 - 40 - 3996   XIM  | 9. Birthplace (State or Foreign Country) |  |  |  |  |
| Maryland Cecil    Top Code   Top  |  |  |  |  |  |
| Mary land    Second   Port Deposit   Total Content of Name   Total Content of  | 10d. Inside City Limits                  |  |  |  |  |
| State of Control of Co | 1 Yes 2 X No                             |  |  |  |  |
| State of Control of Co | nat Country?                             |  |  |  |  |
| Plysician Medical Naminer  23. Part I. Enter the disease, or complications that caused this death. Do not enter the mode of dying, such as cardac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate cause (Final date) is constituted to the constitution of the cause (Part of the Cause China Cause) in a cause on each line. Immediate cause (Final date) is constitution for constitution resulting in death). Security list conditions: The constitution of the cause (Part of the Cause) in the cause on each line. Immediate cause. Enter Underlying Cause (Caesas or Injury that Initiated events resulting in death). Last of the cause (Part of the Caesas or Injury that Initiated events resulting in death). Last of the cause (Part of the Caesas or Injury that Initiated events resulting in death). Last of the cause (Part of the Caesas or Injury that Initiated events resulting in death). Last of the caesas of the cause (Part of the Caesas or Injury that Initiated events resulting in death). Last of the caesas of the cause (Part of the Caesas or Injury that Initiated events resulting in death). Last of the caesas |  |  |  |  |  |
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| The control of the    | 56                                       |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading informedate or conditions resulting in death)  Sequentially list conditions, if any, leading informedate or conditions (Closease or injury that initiated events resulting in death)  Sequentially list conditions, if any, leading informedate or conditions (Closease or injury that initiated events resulting in death)  Sequentially list conditions, if any, leading informedate or conditions (Closease or injury that initiated events resulting in death)  Sequentially list conditions, if any, leading to immediate events resulting in death)  Sequentially list conditions, if any, leading to immediate events resulting in death)  Sequentially list conditions, if any, leading to immediate events resulting in death)  Sequentially list conditions, if any, leading to immediate events resulting in death)  Sequentially list conditions, if any, leading to immediate events resulting in death)  Sequentially list conditions, if any, leading to immediate events resulting in death)  Sequentially list conditions, if any, leading to immediate events resulting in death but not resulting in the underlying cause given in Part I.  Hypertensive atherosclerotic cardiovascular disease; Diabetes  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Hypertensive atherosclerotic cardiovascular disease; Diabetes  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  We so as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as | Between Onset and                        |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cents resulting in death) Last a consequence of):    The condition of the condition | Death                                    |  |  |  |  |
| Part   Land      |  |  |  |  |  |
| WENDED   1   FEMALE:   23c. If yes, outcome of pregnancy   23d. Date of delivery   23d. Date of Date o |  |  |  |  |  |
| WENDED   1   FEMALE:   23c. If yes, outcome of pregnancy   23d. Date of delivery   23d. Date of Date o |  |  |  |  |  |
| past 12 months?    Type 2   No 9   Unknown   |  |  |  |  |  |
| past 12 months?    Type 2   No 9   Unknown   |  |  |  |  |  |
| 29b. Signature and title of certifier  29c. License number O.C.M.E.  30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature  | of delivery Day Year                     |  |  |  |  |
| 29b. Signature and title of certifier  29c. License number O.C.M.E.  30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature  |  |  |  |  |  |
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| 29b. Signature and title of certifier  29c. License number O.C.M.E.  30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature  | due to the cause(s)                      |  |  |  |  |
| 30. Name and address of terson who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature  | ned (Month, Day, Year)                   |  |  |  |  |
| Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | 7, 2008                                  |  |  |  |  |
| State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |  |  |  |  |  |
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** BALLARD GILES 0635 HELEN ELIZABETH COLTRANE 0 08 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country)
N. Carolina 8. Date of Birth (Month, Day, Aug 10 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1917 **Funeral** Months Days 1 M 2 F Aug 227-18-5729 90 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County la or 28a-f show t be notified at 28a-f shov 1 ☐ Yes 2 X No Maryland Anne Arundel Arno1d Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21012 102 Green Valley Rd. item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must t filed within 72 hours after death Hygiene. 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Virginia Elementary/Secondary (0-12) College (1-4or 5+) State University Director of Computers 12th 4yrs permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beatrice Simms John Robert Coltrane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Arnold, Md. 21012 James M. Ballard II(Son) 102 Green Valley Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Blandford Cemetery 1-26-08 Petersburg, Va. 4 ☐ Donation 5 ☐ Other (Specify) Mame Record & Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 MOD483 lead 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1-UMONIA Physician /Medical Due to (or as a consequence of): Examiner 15EASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical as the l IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Deetal death 3 Fctopic pregnancy Month Day for in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 2 No certificate 1□ Yes To the Hospital or Attending Physician: director, 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA <sup>2</sup> this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Magner of Death 28c. Injury at Work? Medical Certification: : After 1 Natural 5 ☐Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No of Funeral Director: At the Funeral Director: At the funeral Director: At the fun 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. sompletely within 24

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) JAN 2 8 2008

**ORIGINAL** 

who completed cause of death (Item 238) (Type, Print)

LATENTATION 44 DEFENSE HEHWAY ANNOUS

32. Registrar's Signature

29d. Date signed (Manth. Day, Year)

ruary 7th 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
VIJAY -S-NAIR M.D 602 S. ATWOODRD. BELAIR MD21014 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death John Horoschak, Jr. 2008 0545 February 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dorchester General Hospital Dorchester Cambridge 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01.15.1926 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Days 1 M 2 F Months : Hours 82 049.16.3878 Connecticut Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Ves 2 No Maryland Caroline Denton 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 400 Fountain Ave. 21629 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Black, White, etc. 1 DYes 2 No If Yes, Give Year or Dates 1943-46 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Product Engineer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Horoschak, Sr. Julia Smarz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 157 St. Cecile Ave., Woonsocket, RI Barbara Fournier/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Sts.Peter&PaulCemetery 2.13.2008 Derby, CI 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 morell 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart latture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumania Due to (or as a consequence of): Dementia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death I□Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an perform Alcorol 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 atural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner as the burial-transit and signed by the attending physician d be detached for use as the buria Division or Vital Records, P.O. cate has been sign page 2 should be To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I

completely filled in by the

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

r than "natural", or Items 23a or the Medical Examiner must be

Director

Funeral

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Completed

Be ၉

Examine

Physician/Medical

Completed

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Certification:

Medical

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with

filed within 72 hours after death

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "n: any Injury or other traumatic event, the Medic 2009.

**Physician** /Medical

Baltimore, Maryland 21215-0036

NOMAN 31. Date filed (Month, Day, Year) Registrar

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

MO

CATBRIDGE MD 21617

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

47924

2-8-08

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THANKY 503

BYRN

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11:12 P Brenda Charlene Hutchins January 28 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4175 Valley Lee Court Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 2₩F 218-52-6334 58 November 8 1949 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 □Yes 2¥7 No ıral", or items 23a or 28a-f sh Examiner must be notified Maryland Calvert Director Prince Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 4175 Valley Lee Court 20678 United States Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. ☐Yes 2 TXNo f Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify. Specify: þ 3 ☐ Widowed 4 H Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) harreneker own hame 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maurice Wilmer Hutchins Verna Mae Buchanan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamara Horsemen - DAUGHIER 4175 Valley Iee Ct. Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place)
Centural Cemetery January 31 2008 Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State Barstow Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Euneral Service Licensee 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** BREAST disease or condition resulting in death) METASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. led by the a detached f 9∏Unknown 9 ☐ Unknown signed t d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ρ 2 No 3 Probably 4 Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has page 2 1 Yes 2 No Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 🛱 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the f within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D 40370

State Registrar

dRW 10

31. Date filed (Month, Day,

PH 50/ke310

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EWS

Registra s Signature

|                            |  |                   | For State Registrar  | State of N  | Maryland                         | d / Depa<br><i>Cei</i>        | artment o<br>rtificate d               | f Hea                   | ılth ar<br>ath           | nd Me                    |   | ene                      | 1 1 25   | 04168  |
|----------------------------|--|-------------------|--|---|----------------------------------|-------------------------------|--|-------------------------|--------------------------|--------------------------|---|--------------------------|--|--|
|                            | Dhysia   |                   | 1. Decedent's Name (First, Middle, Li  | ast)  |                                  |                               |  |                         |                          | 2                        | Date of Death                                 |                          | Voor   | 3. Time of Death   |
|                            | Physici<br>Medi  |                   | Mousa Sa:  | leh   | Haddad                           | l                             |  |                         |                          | J                        | anuary  | 27,                      | 2008   | 6:05 P M   |
|                            | Examir   | ner               | 4a. Facility Name (If not institution, gi  |   | er)                              |                               | 4b. City, Tow                          | n, or Loc               | ation of [               | Death                    |   | 4c. Co                   | ounty of Death                                     |  |
|                            | ·  |                   | 9445 Holsey Road  5. Social Security Number 6.   |   | A // /-                          | - A & / A & - A               | Dama<br>If Under 1 Ye                  | scus                    | S<br>Under 24            | Um la                    | Data of Pint                                  |                          |  | gomery   |
|                            | Funeral Director   |                   |  | 12⊠M 2□F  | Age (In yrs. la<br>63            | as <i>t birtnday)</i><br>Yrs. | Months Da                              |                         |                          | Min.                     | Date of Birth (Month, Day,                    |                          | Cou  | place (State or Foreign<br>ntry)<br>ordan                  |
| 5                          | - Anap   |                   | Usual Residence of Decedent  |   | 0.5                              |                               |  |                         |                          |                          | oril 23                                       | , 19                     | 44 00  | ordan  |
|                            | yland<br>how   | l.                | 10a. State 10b. County   |   | 10c. City,                       | , Town or Lo                  | cation                                 |                         |                          |                          |   |                          |  | 10d. Inside City Limits                                    |
|                            | the Marylar<br>28a-f show<br>notified at   | cto               | Maryland 1   | Montgomery  | 7                                | Damas                         | cus                                    |                         |                          |                          |   |                          |  | 1 ☐ Yes 2 ☐ No   |
|                            | or 28  | Director          | 10e. Street and Number   |   |                                  |                               | 10f. Zip Coo                           | de                      |                          |                          | 10  | g. Citizer               | of What Cou  | ntry?  |
|                            | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or Items 23a or 28a-f show<br>ant, the Medical Examiner must be notified at  |                   | 9445 Holsey Ro   | 7   |                                  |                               | 208                                    |                         |                          |                          |   | US                       |  |  |
|                            | ltem<br>ner n  | Funeral           | 11. Marital Status  1 ☐ Never Married 2√☐ Married  | 12. Was Deceder   | s?                               | 3. 13.                        | Was Decedent<br>If Yes, specify (      | of Hispai<br>Cuban, M   | nic Origin<br>Iexican, F | i? (Specif<br>Puerto Ric | y Yes or No-<br>can, etc.)                    | 14.                      | Race - Americ<br>Black, White,                     |  |
| 36                         | ırs af<br>al", or<br>xaml  | by                | 3 ☐ Widowed 4 ☐ Divorced   | 1 □ Yes 2 v<br>if Yes, Give<br>Year or Dates                    | <u>2</u> 110<br>3:               |                               | 1□Yes 2√x                              | No S                    | pecify:                  |                          |   | Sp                       | <sup>oeci</sup> Whit∈                              | 9  |
| ŏ                          | 2 hou  |                   | 15. Decedent's E   | Education   |                                  | 16a. Dece                     | dent's Usual Oc                        | cupation                | 1                        |                          | 1 1   | 6b. Kind                 | of Business/In                                     | ndustry  |
| 215                        | within 7<br>ene.<br>than "n<br>he Medi   | ) ple             | (Specify only highest gi   | rade completed)  College (1-4o                                  | or 5+)                           | life.                         | kind of work do<br>DO NOT use re       | one durin<br>tired)     | ig most o                | t working                |   |                          |  |  |
| 2                          | er th  | Completed         | 12   |   |                                  | Plum                          | ber                                    |                         |                          |                          |   |                          | -Employ  | red  |
| pu                         | be fill<br>d oth<br>even   | Be                | 17. Father's Name (First, Middle, Las  | ,   |                                  |                               |  | 18.                     |                          |                          | First, Middle, M                              | laiden Su                | rname)   |  |
| Σ́β                        | 12 should be filed withir<br>h and Mental Hygiene.<br>7 Is marked other than<br>traumatic event, the Me  | ျင                | Saleh Issa Hadda   |   |                                  | l                             |  |                         |                          |                          | laddad  |                          |  |  |
| Maryland 21215-0036        | s 1 and 2 should be filed within 72 hours after death with the Maryls f Health and Mental Hygliene. I health and Mental Hygliene aftern 27 Is marked other than "natural", or Items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at  |                   | 19a. Informant's Name/Relationship Laila Haddad/Wife   |   |                                  |                               | ng Address (Str<br>45 Hols             |                         |                          |                          |   | •                        |  | p Code)  |
| بة                         | ges 1 and 2<br>t of Health<br>If item 27 I<br>or other tra   |                   | 20a. Method of Disposition   | •   | 20b. Pla                         | ace of Dispo                  | sition (Name o                         | f                       | TOau,                    | Date                     | e   2   |                          | tion - City or To                                  | own State  |
| nor                        | ages<br>ent of<br>t: If it<br>y or o   |                   | 1 Burial 2 □ Cremation 3 [   |   | te <i>ce</i>                     | metery, crei                  | matory or other                        | place)                  |                          | Jan.                     | 30,   |                          | •  |  |
| Baltimore,                 | permit. Pages 1 a Department of He Important: If item any Injury or oth  |                   | 4 ☐ Donation 5 ☐ Other (Spec<br>21. Signatore of Funeral Service Lice  |   | Gate                             | 22                            | eaven C                                | dress of                | Facility                 | 200                      |   |                          |  | ing, Marylan   |
| ñ                          | Dep Per any  |                   | Algeres 7  | Dasler  | _                                | F                             | rancis                                 | J. (                    | Colli                    | ns F                     | uneral  | Home                     | e Inc.   | ng, MD 2090  |
|                            | Physician /Medical Examiner panial-transit   | al Examiner       | 23a. Pant1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Lun Can  Due to (or a   | line.                            | ence of):                     | er the mode of                         | dying, su               | uch as ca                | rdiac or r               | espiratory arre                               | st,                      |  | Approximate<br>Interval Between<br>Cnset and Death         |
| P.O. Box 687               | Attending Physician: The law requires that the death certificate be executed refeath. The taken this certificate has been signed by the attending physician and ector. After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit   | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | d.  23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown | 2 Fetal at time of de            | death 3⊑<br>ath 5⊑            | Ectopic pregna                         | /)                      |                          |                          |   |                          | f. Date of deliver Month                           | Day Year   |
| ,<br>S                     | ires the signeral signeral laberal   | by                | Part II. Other significant conditions  | contributing to death   | Dut not resu                     | ung in ule ul                 | ndenying cause                         | given in                | Part I.                  |                          |   |                          |  | the cause of death? bably 4 Unknown                        |
| Ö                          | w requires to been signer should be a  | etec              |  |   |                                  |                               |  |                         |                          | - 1                      |   |                          |  |  |
| Division or Vital Records, | ilcian: The lav<br>certificate has<br>ector, page 2 s  | Completed         |  |   |                                  |                               |  |                         |                          |                          | 24a. Was an<br>autopsy<br>perform<br>1∐ Yes 2 | ned?                     | 24b. Were auto<br>prior to co<br>death?<br>1 ☐ Yes | opsy findings available<br>ompletion of cause of<br>2 ☐ No |
| <u>Kit</u>                 | ding Physician: h. After this certific funeral director,   | Be                | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No  | Hospital: 1 I Inpa  | 4:4 000                          | 700 4                         |  | Othor:                  |                          |                          | Check only one                                | ,                        |  |  |
| ō                          | Physer this eral di  | <u>1</u>          | 27. Manner of Death  | 28a. Date of In   | njury :                          | 28b. Time of                  | I SU DOA                               | Injury at<br>Work?      | Nursi                    |                          | 5 X Resider                                   |                          |  | fy)  |
| on                         | nding<br>th.   | tio               | 1 Natural 5 Pending 2 Accident investigation   |   | Day Year)                        | Injury                        |  |                         | 2                        |                          |   |                          |  |  |
| =                          | al or Attend<br>s after death<br>al Director:  | Certification:    | 3 ☐ Suicide 6 ☐ Could not be determined  | 28e. Place of II  | njury - At hon<br>etc. (Specify) | ne, farm, str                 | eet, factory, offi                     | ice                     |                          | 28f                      | Location (Str. City or Town,                  | eet and N<br>State)      | lumber or Run                                      | al Route Number,   |
|                            | To the Hospital or , within 24 hours after To the Funeral Dire completely filled in the complete of the comple | Medical (         | 29a. Certifier (Check only one)  1 ☼ Certifying P 2 ☐ Medical Exa  | hysician: To the bes<br>miner: On the basis<br>and manners      | of examination                   | rledge, death<br>on and/or in | n occurred at the<br>vestigation, in r | ne time, d<br>my opinio | date and pon, death      | olace, and               | d due to the ca<br>at the time, da            | use(s) an<br>ate and pla | nd manner as s<br>ace, and due t                   | stated.<br>to the cause(s)                                 |
|                            | Voith Com  | Σ                 | 29b. Signature and title of certifier  | 1   | <u> </u>                         | A 1=                          |  | ense nur<br>3563        |                          |                          |   |                          | igned (Month,                                      |  |
|                            | D  |                   |  | VV  | V                                | NU                            |  | 3.503                   |                          |                          |   | anua                     | ry 28,   | 2008   |
| . ,                        |  |                   | 30. Name and address of person who   | _   |                                  |                               |  | 63                      |                          |                          | 20022   |                          |  |  |
|                            | -01  |                   | Joseph Kaplan, M 31. Date filed (Month, Day, Year)   | 20222   | Prince<br>strar's Signatu        |                               | lip Dr.                                | Oln                     | ney,                     | MD                       | 20832   |                          |  |  |
|                            | Sta<br>Registr   |                   |  | 108 Santegis  | di s signati                     | do                            | and a                                  |                         |                          |                          |   |                          |  |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** <u>4:</u>45P <sup>M</sup> Gahim H. 1-19 y wock JANUARY 26, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex Birthplace (State or Foreign Country) **Funeral** Year) 1 → M 2 □ F Months Days Director 105 58 7372 70 DEC.02,1937 **ENGLAND** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 ☐Yes 2 🙀 No MARYLAND | ANNE ARUNDEL Director DAVIDSONVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 WHISPERING OAKS LANE 21035 ENGLAND Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give **X** "natural", or items dical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates Specify Specify: WHITE Completed by 3 Widowed 4 Divorced other than "natured yent, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 INSURANCE UNDERWRITER INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nd 2 should be fi th and Mental H 27 Is marked ot r traumatic ever HERBERT HAYWOOD MARY SHAW Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a CONSTANCE L. HAYWOOD (WIFE) 303 WHISPERING OAKS LANE DAVIDSONVILLE, MD. 21035 item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State permit. Page Department o important: If any injury or once. = 5 4 □ Donation 5 □ Other (Specify) KALAS CREMATORY 01-28-2008 EDGEWATER.MD. 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Puncciatic **Physician** CANCET MINTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial-Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical the g as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? Yes 2. No 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: ပို 1 Inpatient 2 TER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred edical Certification: or Attending 1 Natural Injury 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident fter death in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours mpletely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

JAN 2 9 2008

ss of person with

30. Name and dd

31. Date filed (Month, Day, Year)



d cause of death (Item 23a) (Type, Print)

ORIGINAL

e Rd Soite 300 Annights MD 21411

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician**  $\mathbf{A}^{\mathsf{M}}$ Jean Elizabeth (Dickson) Holroyd 25, 2008 6:40 January /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1927 North Carolina Director 80 244-36-8907 Aug 28, Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan attment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ortant: If Item 27 is marked other than "natural", or Items 29a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XX No Directo Maryland | Queen Anne's Chester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5013 Bridgepointe Drive 21619 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, GivX X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXVo White Specify Specify: \$ 3 XVidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Construction -Elementary/Secondary (0-12) College (1-4or 5+) Communications Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Calvin Bryant Dickson Sarah Elizabeth Minshen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda N. Touzin / Daughter 410 1st Street Annapolis, Maryland 21403 20c. Location - City or Town State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Pages 1 Department of H Important: If Itel any injury or otl 1√D/Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) Guilford Mem. Park 1/30/2008 Greensboro, Carolina 21. Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Michile 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Fibrosis >1year /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 9 Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2√No 3 Probably 4 Unknown <u>Pneumonia</u> 1 ☐ Yes Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 📆 🔥 1X Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending XX Natural 2 Accident 5 Pending investigation Injury death. 1 Yes 2 No 24 hours after death Pruneral Director: 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year) JAN 2 9 2008 Registrar

VI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Peterson, M.D. AAMC 2001 Medical PArkway Annapolis, MD 21401 Eleve It Spark

DHMH 17 Rev 1/2001

D 24804

1-25-08

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                               |   |                       | For<br>State<br>Registrar  |  | State of Ma   | rylan       | d / Departm<br><i>Certific</i>                 |  |                             | and Me                              | ntal H                    | ygiene<br>Reg. No        | 200  | 8 04169  |
|-------------------------------|---|-----------------------|--|--|---|-------------|--|--|-----------------------------|-------------------------------------|---------------------------|--------------------------|--|--|
|                               | Physici   |                       | 1. Decedent's Name  AUDREY M   | (First, Middle, Last<br>ICCARTY H          | ,   |             |  |  |                             | i                                   | . Date of I<br>Month      | Da                       |  | 3. Time of Death                                 |
|                               | /Medic<br>Examin<br>Funeral<br>Director   |                       | 4a. Facility Name (If r<br>Memorio<br>5. Social Security Nur<br>182–18–61              | not institution, give                      | street and number)  | (In yrs. It | E  | City, Town, o                          | If Under                    | of Death                            | Date of E                 | 4c.                      | County of Dea                                | th   |
|                               | and w   |                       | Usual Residence of D<br>10a. State   | Decedent<br>10b. County                    |   | 10c City    | , Town or Location                             |  |                             |                                     |                           | ,                        |  | 10d. Inside City Limits                          |
|                               | Maryla<br>f sho   | tor                   | MD   | TALBOT                                     |   | roo. ony    | EASTON   |  |                             |                                     |                           |                          |  | 1 XYes 2 □ No                                    |
|                               | th the or 28a e notif   | irec                  | 10e. Street and Numl   | Der  |   |             |  | Zip Code                               |                             |                                     |                           | 10g. Cit                 | izen of What Co                              | ountry?  |
|                               | ath wil   | ral                   | 545 CYNWO  | OD DRIVE                                   | , APT. 109  |             |  |  | 21601                       |                                     |                           |                          | USA  |  |
| 9036                          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifled at once. | d by Funeral Director | 11. Marital Status 1 □ Never Marrie  |  | 12. Was Decedent E<br>Armed Forces?<br>1 Tyes 2 No.<br>If Yes, Give<br>Year or Dates: | ver in U.S  | 1  | ecedent of H<br>specify Cub<br>s 2 XNo |                             | igin? (Specit<br>n, Puerto Ri       | fy Yes or I<br>can, etc.) | 10-                      | 14. Race - Ame<br>Black, Whit<br>Specify: WH | te, etc.   |
| 15-(                          | n 72 h<br>' <b>'nat</b> u<br>edica  | lete                  | (Specif  | 5. Decedent's Edu<br>only highest grad     | le completed)   |             | 16a. Decedent's<br>(Give kind o<br>life, DO NO | work done                              | during mos                  | t of working                        |                           | 16b, K                   | ind of Business                              | /Industry  |
| 212                           | d withi<br>giene.<br>rr than<br>the M   | Completed             | Elementary/Second  | dary (0-12)                                | College (1-4or 5+   | -)          |  | AGER                                   | <b>0</b> /                  |                                     |                           | -                        | BOOK ST                                      | ORE  |
| hadrey<br>Maryland 21215-0036 | uld be file<br>Mental Hy,<br>rked othe<br>tic event,  | To Be C               | 17. Father's Name (F   |  | RTY   |             |  |  | 18. Mothe                   | er's Name <i>(I</i><br><b>JENNY</b> |                           |                          | Surname)                                     |  |
| ∫<br>∕lan                     | 12 sho<br>n and l<br>is ma<br>rauma   |                       | 19a. Informant's Nan   |  | . ,   |             | 19b. Mailing Add                               |  |                             |                                     |                           |                          | or Town, State,                              | Zip Code)  |
| re, r                         | Health  |                       | CLINTON C  |  | II/SUN  | 20b. PI     | 4 RIDGE  | Name of                                | 1                           | Dat                                 |                           |                          | ocation - City or                            | Town, State                                      |
| Heyd<br>more,                 | Pages<br>tent of<br>int: If i   |                       |  | Cremation 3 ☐F                             | Removal from State  | 1           | emetery, crematory<br>LEGHENY C                | -                                      |                             | 2/7/2                               | 800                       | PI                       | TTSBURG                                      | H, PA  |
| Heyd<br>Baltimore,            | permit. Departm Importa any Inju  |                       | 21. Signature of Fundamental   | eral Service Licens                        | merce   |             | 22. Nam  | e and Addre                            | ess of Facili               | BEIN                                | & NEV                     | VNAM :                   |  | HOME PA  |
|                               | 100   |                       | 23a. Part1. Enter the  | disease, or comp                           | lications that caused to<br>ne cause on each line                                     | he death    |  |  |                             |                                     |                           |                          | KILIZIND                                     | Approximate<br>Interval Between                  |
|                               | Physician   |                       | Immediate Cause (Fi  |  | a. Pancr  | east        | ita  |  |                             |                                     |                           |                          |  | Onset and Death                                  |
| 7                             | /Medical<br>Examiner  |                       | resulting in death)  |  | Due to (or as a   | consequ     | ence of):                                      |  |                             |                                     |                           |                          |  |  |
|                               |   | Jer                   | Sequentially list condificant, leading to immoduse. Enter Underly Cause (Disease or in | litions,<br>nediate                        | b. Duy to (or as a  | consequ     | ence of):                                      |  |                             |                                     |                           |                          |  |  |
|                               | ficate be executed<br>physician and<br>is the burial-transit  | Examin                | Cause (Disease or in<br>that initiated events<br>resulting in death) La                |  | · Prem  | non         | <u> </u>                                       |  |                             |                                     |                           |                          |  |  |
| 68760,                        | be ex   |                       |  |  | Due to (or as a   | consequ     | ence of):                                      |  |                             |                                     |                           |                          |  |  |
| 687                           | ficate<br>phy:<br>s the   | ledical               |  |  | d   |             |  |  |                             |                                     | -                         |                          |  |  |
| O. Box                        | The law requires that the death certifi<br>ate has been signed by the attending<br>page 2 should be detached for use as   | Physician/M           | IF FEMALE: 23b. Was decedent print the past 12 mm 1 Yes 2 9 Unknown                    | onths?                                     | 23c. If yes, outcome p<br>1□Live birth 2<br>4□Pregnant at t<br>9□Unknown              | 2 ☐ Fetal   | death 3 ☐Ectop                                 | ic pregnanc<br>(specify)               | у                           |                                     |                           |                          | 23d. Date of de<br>Month                     | livery<br>Day Year                               |
| , P.O                         | that the dened by the stacked is  |                       | Part II. Other signific  | ant conditions co                          | ntributing to death but   | t not resu  | Iting in the underlyi                          | ng cause giv                           | ven in Part I               |                                     | 23e. Dio                  | f tobacco u              | use contribute to                            | the cause of death?                              |
| rds                           | w requires to been signer should be   | ed by                 | Atrial   | 5/balla                                    | roits   |             |  |  |                             |                                     | 1 [                       | Yes 2                    | KQ No 3□P                                    | robably 4  ☐Unknown                              |
| eco                           | law re  | Completed             | Demen  | tia_                                       |   |             |  |  |                             |                                     | 24a. Wa                   | is an                    | 24b. Were at                                 | utopsy findings available completion of cause of |
| <u>~</u>                      | : The   | Con                   |  |  |   |             |  |  |                             |                                     | pe                        | rformed?<br>2 ☑No        | death?                                       | •  |
| ∠<br>Et                       | Physician: The law<br>rthis certificate has t<br>ral director, page 2 s   | ) Be                  | 25. Was case referre examiner? 1 ☐ Yes 2 ♠ N   | F7   | -lospital:  | + 2 D E     | ER/Outpatient 3□                               | DOA Oth                                | OF:                         | of Death (0                         |                           |                          |  |  |
| יס ר                          | g Phy<br>ter this<br>neral d  | n: To                 | 27. Manner of Death  |  | 28a. Date of Injury   | /           | 28b. Time of Injury                            | 28c. Injui<br>Wor                      |                             |                                     |                           |                          | 6 □Other (Spe<br>ry occurred                 | icify)   |
| sior                          | or Attending<br>ifter death.<br>Director: After<br>in by the fune   | atio                  | 1 TNatural 2 ☐ Accident  | 5 ☐ Pending investigation 6 ☐ Could not be | (Wonar, Day   | (car)       | М  |  | Yes 2□                      | No                                  |                           |                          |  |  |
| Division or Vital Records,    | tal or Att<br>rs after de<br>al Direct<br>led in by   | Certification:        | 3 ☐ Suicide<br>4 ☐ Homicide  | determined                                 | 28e. Place of injur<br>building, etc.   |             | ne, farm, street, fac                          | tory, office                           |                             | 281                                 | . Location<br>City or 7   | (Street an<br>own, State | nd Number or Ri                              | ural Route Number,                               |
|                               | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral  | Medical               | 29a. Certifier 1<br>(Check only 2<br>one) 2  | CertifyIng Phy Medical Exami               | sician: To the best of<br>iner: On the basis of<br>and manner stat                    | examinati   | vledge, death occur<br>ion and/or investiga    | red at the ti<br>tion, in my o         | me, date ar<br>opinion, dea | id place, and<br>ath occurred       | d due to th<br>at the tim | e, date and              | ) and manner as<br>d place, and du           | s stated.<br>e to the cause(s)                   |
|                               | vithi<br>To t   | Σ                     | 29b. Signature and til   | le of certifier                            | 1   |             |  | 29c. Licens                            | e number                    | ,                                   |                           | 29d. Dat                 | te signed (Mont                              |  |
|                               |   |                       | Den  | 1 Sun                                      | 1, mv)  | . 11. 11:   |  | NPP                                    | 547                         | 62                                  |                           | 01/2                     | 41.7   | 008  |
|                               |   |                       | 30. Name and address   | s of person who co                         | ompleted cause of dea   | ath (Item   | 23a) (Type, Print)                             | Stony                                  | MD                          |                                     |                           |                          |  |  |
|                               | Sta   |                       | 31. Date filed (Month  | Day, Year)                                 | 32. Registrar   | 's Signat   | ure  |  |                             |                                     |                           |                          |  |  |

Division or Vital Records, P.O. Box 68760,

|   | •  | 1 - State<br>Registrar   |  |   | viai y iai                     | Ce                      | ertificate of   |                      |                 |  | Reg. No.  | 2008  | 04                                | 170                  |  |
|---|--|--|--|---|--------------------------------|-------------------------|---|----------------------|-----------------|--|---|---|-----------------------------------|----------------------|--|
| Physici   | ian  | 1. Decedent's Name (First, Mid   | dle, Last  | ,   | <u> </u>                       |                         |   |                      |                 | 2. Date of De<br>Month                     |   | / Year  | 3. Time of                        | Death                |  |
| /Medi   |  |  |  | Arthur                                    |                                | nes                     |   |                      |                 | January                                    | 26,   |   | 1845                              | М                    |  |
| Examir  | ner  | 4a. Facility Name (If not institut<br>Calvert Memorial H   |  |   | er)                            |                         | 4b. City, Town, o   |                      | of Death        |  | ı   | County of Deatl  vert                           | 1                                 |                      |  |
| Funeral<br>Director   |  | 5. Social Security Number <b>218-14-3443</b>   | 6. Se  | х<br>Ум 2□F                               | Age (In yrs.                   | last birthda<br>85 Yrs. | y) If Under 1 Year<br>Months Days                                 | If Unde<br>Hours     | Min.            | 8. Date of Bir<br>(Month, Da<br>July 3, 19 | ıy, Year)   | 9. Birth<br>Con<br>MD                           | nplace (State o<br>untry)         | or Foreign           |  |
| and w   |  | Usual Residence of Decedent  10a, State  10b, Coun   | tv   |   | 10c. Cit                       | ty, Town or I           | Location  |                      |                 |  |   |   | 10d. Inside Ci                    | ity Limite           |  |
| Maryle<br>f sho   | 5  | MD Calve   |  |   |                                | sapeak                  |   |                      |                 |  |   |   | 1 ☐ Yes                           |                      |  |
| the last  | Director   | 10e. Street and Number   |  |   |                                |                         | 10f. Zip Code   |                      |                 |  | 10g. Citi   | zen of What Co                                  | untry?                            |                      |  |
| h with<br>23a ol<br>st be   |  | 7002 Old Bayside F   | Road   |   |                                |                         |   | 20732                |                 |  | USA   |   |                                   |                      |  |
| r deat<br>ems ?   | Funeral  | 11. Marital Status   |  | 12. Was Decede<br>Armed Force             | ent Ever in U                  | .S. 13                  | B. Was Decedent of H<br>If Yes, specify Cuba                      |                      | rigin? (Spe     | cify Yes or No                             | rican Indian,<br>e, etc.                          |   |                                   |                      |  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland<br>Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or items 23a or 28a-f show<br>any Injury or other traumatic event, the Medical Examiner must be notitied at<br>once. | þ  | 1 ☐ Never Married 2 ☐ Ma<br>3 ☐ Widowed 4 ☑ Divorce  |  | 1 ☐ Yes 2<br>If Yes, Give<br>Year or Date | No                             |                         | 1 ☐ Yes 2 ☒ No  | Specify              |                 |  | lack  |   |                                   |                      |  |
| 72 hc<br>'natur<br>dical  | eted   | 15. Decede<br>(Specify only high   | ent's Edu<br>est grad  | ication<br>le completed)                  |                                | 16a. Dec                | edent's Usual Occup<br>re kind of work done<br>DO NOT use retired | ation<br>during mo   | st of worki     | ng   | 16b. Kind of Business/Industry                    |   |                                   |                      |  |
| vithin<br>ene.<br>than '  | Completed  | Elementary/Secondary (0-12)  |  | College (1-4                              | or 5+)                         |                         |   |                      | Franciscon C    | 24   |   |   |                                   |                      |  |
| filed v<br>Hygie<br>Ither 1   | ပ္တို  | 6<br>17. Father's Name ( <i>First, Middl</i>   | e. Last)   |   |                                | ] Iruc                  | k Driver  | er's Name            | (First, Middle, |  | Furniture S                                       | store   |                                   |                      |  |
| lid be<br>lental<br>ked c   | To Be  | F  | rnest  | Jones                                     |                                |                         |   |                      |                 | _  |   | letcher   |                                   |                      |  |
| shou<br>and M<br>s mar  | -  | 19a. Informant's Name/Relation   |  |   |                                | 19b. Mai                | iling Address (Street   | and Numb             | er or Rura      |  |   |   | ip Code)                          |                      |  |
| and 2<br>salth a<br>n 27 is   |  | Noble S. Jones - Brother 43 Hamilton Street NW, Washington, DC 20011   |  |   |                                |                         |   |                      |                 |  |   |   |                                   |                      |  |
| jes 1<br>of He<br>If item   |  | 20a. Method of Disposition  1  |  |   |                                |                         |   |                      |                 |  |   |   |                                   |                      |  |
| Pag<br>ment<br>tant:  |  | 1 ⅓ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Ernestine Jones Cemetery 2/1/2008  Chesapeake Both   |  |   |                                |                         |   |                      |                 |  |   |   |                                   |                      |  |
| permit<br>Depar<br>Impor<br>any In<br>once.   |  |  |  |   |                                |                         |   |                      |                 |  |   |   |                                   |                      |  |
| Physician<br>/Medical   |  | 23a. Part1. Enter the disease,<br>shock, or heart failure. Li<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | or compl<br>st only o  | ne cause on eac<br>a. Hyli                | n line.                        |                         |   |                      |                 |  | y arrest, Approximate Interval Betwe Onset and De |   |                                   |                      |  |
| Examiner  | er   | Sequentially list conditions, if any, reading to immediate   |  | Bran                                      | as a conseq<br>do a conseq     |                         |   |                      |                 |  |   |   |                                   |                      |  |
| rtificate be executed<br>ng physician and<br>as the burial-transit  | Examiner   | day, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             | 1  | c   | as a conseq                    | uence of):              |   |                      |                 |  |   |   |                                   |                      |  |
| cate be only sicial the buri  | Medical  |  |  | d   |                                |                         |   |                      |                 |  |   |   |                                   |                      |  |
| ng ag   |  | IF FEMALE:<br>23b. Was decedent pregnant   | 2  | 23c. If yes, outco                        |                                |                         |   |                      |                 |  |   | 23d. Date of deli                               | verv                              |                      |  |
| w requires that the death ce<br>been signed by the attendir<br>should be detached for use   | Physician/   | in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  |  | 1□Live birti<br>4□Pregnan<br>9□Unknow     | t at time of d                 |                         | ☐ Other (specify)   | /                    |                 |  |   | Month   | Day                               | Year                 |  |
| s that<br>gned t  | by P   | Part II. Other significant condi   | tions co   |   |                                | ulting in the           | underlying cause giv  | en in Part           | ŧ.              | 23e. Did to                                | obacco u  | se contribute to                                | the cause of d                    | leath?               |  |
| equire<br>en sig<br>ould b  | pa   | Strep preys  | nc   | Julum                                     | me 15                          |                         |   |                      |                 | 10   | Yes 2[  | □ No 3 □ Pro                                    | bably 4 🎉                         | nknown               |  |
| The law requires that the death ce atendiate has been signed by the attendionage 2 should be detached for use   | Completed  |  |  |   |                                |                         |   |                      |                 | 24a. Was<br>autor<br>perfo<br>1□ Yes       |   | 24b. Were au<br>prior to c<br>death?<br>1 ☐ Yes | topsy findings<br>completion of c | available<br>ause of |  |
| cian:<br>ertifica<br>ctor, I  | BeC  | 25. Was case referred to medic examiner?   | al   |   |                                |                         |   | 26. Plac             | e of Death      | (Check only o                              |   | 1 100   |                                   |                      |  |
| hysio<br>this or<br>al dire   | ၉ ု  | 1 Yes 2 No   | 1  | Hospital: 1 Inp                           |                                | ER/Outpatie             |   | 4 LJ N               |                 |  |   | 6 □Other (Spec                                  | ify)                              |                      |  |
| ending Path.<br>or: After i   | ation:   | E LI / tooldont  | tigation   | 28a. Date of I<br>(Month,                 | njury<br>Day Year)             | 28b. Time<br>Injury     | Wor   | yat<br>k?<br>Yes 2 ⊑ |                 | 28d. Describe I                            | how injur   | y occurred                                      |                                   |                      |  |
| tal or Ath  | Certification:   | 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter   | not be<br>mined  |   | injury - At ho<br>etc. (Specif |                         | treet, factory, office  |                      | 2               | 8f. Location (8<br>City or Tov             |   | d Number or Ru<br>)                             | ral Route Num                     | nber,                |  |
| To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.   | 29a. Certifier  (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29c. License number |  |  |   |                                |                         |   |                      |                 |  |   | and manner as<br>I place, and due               | stated.<br>to the cause(s         | s)                   |  |
| To t<br>with<br>To t  | M  | 29b. Signature and title of certif   | 29c. License number  FCO426761  29d. Date signed (Month, Day, Year)  1/28/08  In who completed cause of death (Item 23a) (Type, Print)  Chun 100 (Cosp. Far Rol Prince Frederick MD) |   |                                |                         |   |                      |                 |  |   |   |                                   |                      |  |
| ) a   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  William Chun M Hospital Rd Print                 |  |  |   |                                |                         |   |                      |                 | lent                                       | M   | D   |                                   |                      |  |
| Sta<br>Registr  |  | 31. Date filed (Month, Day, Yea JA   |  | 8 2008                                    | istraris Signa                 | ature                   | Sports  |                      |                 |  |   |   |                                   |                      |  |
|   |  |  |  |   |                                |                         |   |                      |                 |  |   |   |                                   |                      |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7:39 a <sup>M</sup> Annie Lee Johnson 26, 2008 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 XF Hours Min. Director 579-24-9261 88 Oct. 16, 1919 Alabama Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2x 3xNo Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4977 Battery Lane, #1016 20814 USA Funeral "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🕱 No Specify: Black 1 ☐ Yes 2 ☒ No Specify: à 3 X Widowed 4 Divorced Completed ed other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked John Lee Cheshier Amanda Ware 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar Health tem 27 Jacqueline Johnson/Daughter 4977 Battery Lane, #1016, Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) permit. Pages
Department of
Important: If it
any injury or or 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 30 Mt. Olivet Cemetery, DC 4 ☐ Donation 5 ☐ Other (Specify) 2008 Washington, DC 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. 23a. Part1. En. r the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ATHOROSCLERONO UEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Let Due to (or as a consequence of). Examine certificate be executed attending physician and for use as the burial-tra resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery requires that the death 3 ☐ Ectopic pregnancy Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify). 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed The law I 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an certificate 1□ Yes Physiclan; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 10 2 NER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 ☐ Pending investigation 1 🗌 Yes 2 🗌 No 3 ☐ Suicide 6 Could not be 4 Homicide

68760 126 or Vital Records, COSTINACI sion To the Hospital or Attending AUVIE within 24 hours a

To the Funeral [

Baltimore, Maryland 21215-0036 500 University Blvd, West, Silver Spring, MD 20901 Certification: I Director: A 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31027 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIEN 8600 OLD 6EUGET OWN 31. Date filed (Month, istrar's Signature State 2008 Registrar DHMH 17 Rev 1/2001 ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** JAMES BRADFORD KNEALE 2008 8:10PM JANUARY 26 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner EASTON TALBOT TALBOT HOSPICE HOUSE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
AUG 29, 1924 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 1**X** M 2□ F 83 OHIO Director 282-18-4921 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10c. Cify, Town or Location 10d. Inside City Limits 10a State 10b County "natural", or items 23a or 28a-f show dical Exa⊡iner must be notified at Yes 2 No Directo TALBOT EASTON MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 USA 700 PORT ST. #210 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE <u>۾</u> 3 ☐ Widowed 4 ☐ Divorced er than "nature the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ENGINEER STATE GOVERNMENT 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALICE BLACKBURN JAMES BRADFORD KNEALE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau
once. 700 PORT ST. #210, EASTON, MD 21601 CAMILLA H. KNEALE/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X3 Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 1/28/2008 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 MERCERON JOHN R. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ung CONCER Mes Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease on Figure that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page certificate 1∐ Yes 250 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: 1 the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical (Check only the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D66270 **JANUARY 28, 2008** 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+VA 8221 TEAL DRIVE, SUITE 302 EASTON, MD 21601 DAVID C. HALVERSON, M.D.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

**ORIGINAL** 

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|            |   | ·                | 1 - State Registrar   | State of M   | aryland / I                                     |  | tment<br>ificate                   |                  |                           | ind Me   |   | giené                      | -000                              | 04174  |
|------------|---|------------------|---|--|---|--|------------------------------------|------------------|---------------------------|--|---|----------------------------|-----------------------------------|--|
|            | Physici   | ian              | 1. Decedent's Name (First, Middle,  | Last)  |   |  |                                    |                  |                           |  | 2. Date of De<br>Month                    | Day                        |                                   | 3. Time of Death 8 11:05A M                        |
|            | /Medic  | cal              | John M. Logar<br>4a. Facility Name (If not institution,   |  |   |  | 4b. City, To                       | wn, or           | Location o                |  | Februa                                    | ary<br>4c.                 | 8,200<br>County of Dea            |  |
|            | LAGITII   |                  | Franklin Woods 5. Social Security Number  | Nursing  | Home  | Carlo de la  | Rose                               |                  |                           | 24 Hrs   | O Date of Pin                             |                            | ltimor                            |  |
| П          | Funeral<br>Director   |                  | 5. Social Security Number 192-26-9888   | 1. Sex 77A(  | ge (In yrs. last bli<br>73                      | Yrs.   |                                    | Days             | Hours                     | Min.   | Month, Da                                 | y, Year)<br>1 <b>y 1</b> 3 | , 1935                            | thplace (State or Foreign<br>buntry)<br>Pennsylvar |
|            | and w   |                  | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Tow                                  | vn or Loca   | ation                              |                  |                           |  |   |                            |                                   | 10d. Inside City Limits                            |
|            | within 72 hours after death with the Maryland<br>ene.<br>than "natural, or items 23e or 28e-f show<br>than "maited Examiner must be notified at | tor              | Delaware New C  | astle  | Midd  | llet   | own                                |                  |                           |  |   |                            |                                   | Y Yes 2 □ No                                       |
|            |   | Funeral Director | 10e. Street and Number  |  |   |  | 10f. Zip C                         |                  |                           |  |   |                            | izen of What Co                   | ountry?  |
|            |   | erai             | 1296 Bayview  | 12. Was Decedent   | Ever in U.S.                                    | 13. Wa   |                                    | 709<br>nt of His |                           | gin? (Spec   | cify Yes or No<br>lican, etc.)            |                            | 14. Race - Ame                    |  |
| 9          | or iter   |                  | 1X Never Married 2 ☐ Marrie   | If Yes, Give   |   | - (  | Yes, specifi<br>☐ Yes <b>X</b> [   |                  | n, Mexican Specify:       | , Puerto F   | lican, etc.)                              |                            | Black, White Specify: Wh          |  |
| 21215-0036 | "natural", or   | ed by            | 3 ☐ Widowed 4 ☐ Divorced  15. Decedent's  |  | 16a   | . Decede   | nt's Usual                         | Occupa           | tion                      |  |   | 16b. K                     | ind of Business                   |  |
| 215        | Jwithin 72 ho<br>piene.<br>r than "natur<br>Ine Medical   | Completed        | (Specify only highest<br>Elementary/Secondary (0-12)  | College (1-4or   | 5+)   | life. DO   | nd of work<br>O NOT use            | retired)         |                           |  |   | Do l                       | iaion                             |  |
| d 21       | be filed wintal Hygien of other the event, In-  | e Cor            | 17. Father's Name (First, Middle, La  | 5 +  |   | coma   | n Ca                               |                  |                           |  | (First, Middle,                           |                            | igion                             |  |
| Maryland   | 2 should be<br>and Mental<br>Is marked of<br>sumatic eve  | To Be            | John J. Logar   | 1  |   |  |                                    |                  |                           |  |   |                            | ellan                             |  |
| اaar       |   |                  | 19a. Informant's Name/Relationshi   |  | 1   |  |                                    |                  |                           |  |   |                            | or Town, State,                   |  |
|            | s 1 and 2<br>if Health<br>item 27   |                  | Reverand Edwa  20a. Method of Disposition   |  | 20b. Place o                                    | of Disposit  |                                    | of               |                           |  | ate                                       |                            | ocation - City or                 | Town, State  |
| Baltimore, | m 0   |                  | 1 □ Burial 2 □ Cremation 3<br>• 4 □ Donation <b>5</b> □ Other (Spe  | B □Removal from State ocityEntombme                                |   |  |                                    |                  |                           | m2-1   | 4-08                                      | Yea                        | don,Pe                            | nnsylvania   |
| Balt       | permit. Page<br>Department<br>Important: If<br>any injury or<br>once.   |                  | 21. Signature of Funeral Service Li   | manulle  | 2   | 60   | Name and                           | rfa              | ord                       | Mar<br>Road  | zullo<br>Road                             | Fu<br>,Ba                  | neral<br>ltimor                   | Chapel,P.A   |
| П          |   |                  | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition  a. Meta Static Dancie Cancer |  |   |  |                                    |                  |                           |  |   |                            |                                   |  |
|            | Physician<br>/Medical   |                  | disease or condition resulting in death)  | a. Preto (or as  | STATIC<br>a consequence                         |  | Danc                               | rec              | atic                      |  | ance                                      | 1                          |                                   |  |
|            | Examiner  |                  | Sequentially list conditions,   | b  |   | ,  |                                    |                  |                           |  |   |                            |                                   |  |
| ,          | nsit  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as  | a consequence                                   | or):   |                                    |                  |                           |  |   |                            |                                   |  |
| ,092       | te be executed<br>ysician and<br>te burial-transit  |                  | that initiated events<br>resulting in death) Last   | Due to (or as  | a consequence                                   | of):   |                                    |                  |                           |  |   |                            |                                   |  |
| 6876       | e K   | dicai            |   | d  |   |  |                                    |                  |                           |  |   |                            |                                   |  |
| Box 6      | death certificat<br>e attending phy<br>id for use as th   | Physician/Med    | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome   | of pregnancy<br>2 Petal death                   | h 3∏E  | Ectopic prec                       | nancy            |                           |  |   |                            | 23d. Date of de                   |  |
| O. B       | 0 0 0   | ysicia           | in the past 12 months?  1  Yes 2  10  |  |   |  |                                    |                  |                           |  |   | Month                      | Day Year                          |  |
| s, P.(     | s that the<br>ned by<br>a detact  | by Ph            | Part II. Other significant condition  | in the und   | underlying cause given in Part I. 23e. Did toba |  |                                    |                  |                           | obacco   | cco use contribute to the cause of death? |                            |                                   |  |
| ords       | w requires<br>been sign<br>should be  |                  |   |  |   |  |                                    |                  |                           |  | 1 🗆                                       | Yes 2                      | 2 No 3 Probably 4 Unknown         |  |
| Record     | e las<br>has  | Completed        |   |  |   |  |                                    |                  |                           |  |   |                            | prior to death?                   | utopsy findings available completion of cause of   |
| Vital      | ing Physician: . After this certifica<br>uneral director, p   | Be C             | 25. Was case referred to medical examiner?  | 26. Place of Death (Check only one)                                |   |  |                                    |                  |                           |  |   |                            |                                   |  |
| of         |   | 2                | 1 ☐ Yes 2 ☐ No  27. Manner of Death   | Hospital:<br>1 ☐ Inpati<br>28a. Date of Inj                        | utpatient<br>Time of                            |  |                                    |                  |                           | ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred |   |                            |                                   |  |
| ion        |   | ation            | 1 ☑Natural 5 ☐ Pending<br>2 ☐ Accident investiga  | (Month, Day Year) Injury   |   |  | 28c. Injury at Work?  M 1 Yes 2 No |                  |                           |  |   |                            |                                   |  |
| Division   | or Attend<br>after death<br>Director: /   | Certification;   | 3 Suicide 6 Could no<br>4 Homicide determin   | ad 286. Place of II  | jury - At home, fa<br>tc. (Specify)             | arm, stree   | et, factory,                       | office           |                           | 2  | 8f. Location (<br>City or To              |                            |                                   | lural Route Number,                                |
|            | Hospita<br>4 hours<br>Funera<br>tely fille  | Medical C        | 29a. Certifier 1 Certifying (Check only one) 2 Medicel E  | Physicien: To the best<br>keminer: On the basis of<br>and manner s | of examination as                               | ge, death o  | occurred at<br>estigation, in      | the tim          | e, date an<br>linion, dea | d place, a<br>th occurre   | nd due to the<br>d at the time,           | cause(s<br>date and        | ) and manner a<br>d place, and du | s stated.<br>e to the cause(s)                     |
|            | To the within 2 To the comple   | Me               | 29b. Signature and title of certifier   | 1  | )   |  | 29c.                               | License          | number                    |  |   | 29d. Da                    | te signed (Mon                    | th, Day, Year)                                     |
| )          |   |                  | Jon Cof   | morebo   | ~_ 11   | (1)  |                                    | DI,              | 157                       | 66   |   | eb                         | rucury                            | 8,2008   |
|            | 6   |                  | 30. Name and address of person w  | no completed cause of  | n Klin S.                                       | (Type, P   | P D                                | . <              | Sto Z                     | 12   | Ba 1+                                     | 1.11                       | re 1                              | 8, 2008<br>4021237                                 |
|            | Sta   | -                | 31. Date filed (Month, Day, Year)   | 107  | rar's Signature                                 | Lac  | ett o                              | 7                | // /                      | - Oy   | 1///                                      | 441                        | 1                                 | 142/   |
|            | Registi   | rar              | FEB 13  | 2008   | U 185"  | A STATE OF THE PARTY OF THE PAR |                                    |                  |                           |  |   |                            |                                   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2008 on /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Malical Center Baltimore tairs Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1**Ϫ**M 2□F Months Days Sept. 18, 1931 PA 209-22-8070 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show Item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2☐No Director WV Hampshire Augusta 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26704 USA HC-71 Box 133A Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **₽** 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner/Operator Market Produce 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gladys Irene Walker Foster Peter Grant Lape 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC-71 Box 133A Augusta, WV 26704 Susa E. Lape 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any Injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Omps Cremation Center 2/8/08 Winchester, VA 4 Donation 5 Other (Specify) e of Funeral Service 22. Name and Address of Facility McKee Funeral Home Inc. 21. Signatur P.O. Box 270 Augusta, WV 26704 23a. Part1. Hitter the disease, or complication: that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non-Small Cell lung Carcinoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (bride a consequence of) Examine anding physician and use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۶ م 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, pege 2 s autopsy performed?

1 Yes 2 No s after deau... ral Director; After this cerumon of the funeral director, pr Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ᇋ 1 ☐ Yes 2 ▼ No 1 npatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation М 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 and manner stated. 29c. License number 2 P 21124 Feb 07, 2008 10 North Greene St. Baltimore, Md 21201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

pore

2008

3

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Year CHARLES CALVIN 1300 LIPSCOMB 02 08 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Ye Jun. 18, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Year 220-34-1470 Director 1941 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County a or 28a-f show be notified at 10a. State 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Allegany LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11304 New York Ave NW USA 21532 "natural", or items 23a edical Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) Machinist Railroad other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I int: If Item 27 Is marked o Wayne B. Lipscomb Hazel M. (Morris) Lipscomb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Lipscomb Wife 11304 New York Ave., NW, LaVale, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If Its any injury or o once. 1 Burial 2 Cremation 3 Removal from State Parsons Cemetery Feb 11 08 Parsons, WV 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hafer Funeral Service, PA 1302 National Hwy., LaVale, MD aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, act line. 23a. P .rt1 Enter the disease, .f. mplications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHRONIC OBSTRUCTIVE PULMONARY DISENSE FOURTEEN /Medical YEARS Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

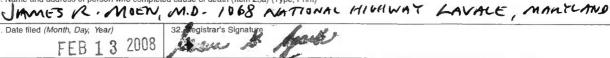
1 □ Yes 2 □ No 24a. Was an has page 2 autopsy perform certificate 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 No 1 Unpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D Textertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

2

31. Date filed (Month, Day, Year) 2008 3

FEB

29b. Signature and title of certif



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License numbe

ስ334(ገ

29d. Date signed (Month, Day, Year)

FEBRUARY 8, 2008

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 State
Registra/NFND#25, 27, 28a-fperND1/31/08, EMW, MCC ertificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1220 PM 27, 2008 David Lee Locket January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Holy Cross Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 59 1948 Washington, DC April 8, Director 216-50-9769 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ¥ Yes 2 □ No Director MD Kensington Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medital Examiner must be 20895 U.S. 3000 McComas Ave. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 \(\overline{\text{Yes}}\) 2 \(\overline{\text{No}}\) No If Yes, Give \(\overline{1}\) 968-70 Year or Dates. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2X No altimore, Maryland 21215-0036 Specify Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vietnam Veteran U.S. Army 11 marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be figure and Mental F Be Mable Brown ပ James Lockett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) ,1 and 2 s if Health a Palsy Lockett / Sister 831 Lake Shore Drive, Bowie, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham Vet. Cem. 2/8/2008 | Cheltenham, MD
22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature/pf Funeral Service Licepsee 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one calls on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Weeks Pneumonia /Medical Due to (or as a consequence of): Examiner Methacillin Resistant Staph Aureus Sepsis Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine as the burial-transi Quadraplegia mo DAD F and P.O. Box 68760 attending physician certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnan 1☐Live birth 2☐ Fetal o nse 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy 2 Fetal deav ō Month Day Year 4☐Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the unverlying cause given in Part I. Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∏ Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 N 1 K Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at Work? il or Attending Platter death. Certification: (Month, Day Year) 5 Pending investigation 2 X Accident 30 yns back unknown motor vehicle accident 281. Location (Street and Number or Rural Route Number, City or Town, State) in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide unknown unknown To the Hospital within 24 hours a To the Funeral I Hospital 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 31. Date filed (Month, Day, Year) **JAN 30** 

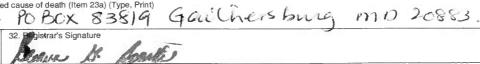
, Namal

NAWA2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b Signature and title of certifier

AHMED



29c. License number

D50987

29d. Date signed (Month, Day, Year)

1-29-08

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  | 1.  | For<br>State   | State of Maryland  | / Department of H   |   |  | ne<br>No.2008                         | 04178                                 |  |  |
|--|---|--|--|---|---|--|---------------------------------------|---------------------------------------|--|--|
|  | 4   | Registrar  Decedent's Name (First, Middle, Last,   |  | 3. Time of Death  |   |  |                                       |                                       |  |  |
| Physician  | _   |  |  |   |   |  | Day Year 28, 2008                     | 1:45p                                 |  |  |
| /Medical   |   | Adelaide Florence  |  | 4b. City, Town, or  | Location of Death                         |  | 4c. County of Death                   |                                       |  |  |
| Examiner   | 48  | a. Facility Name (If not institution, give   |  |   | 2004101101                                |  | Montgom                               | erv                                   |  |  |
|  |   | Montgomery Genera  |  | olney  st birthday) If Under 1 Year   | If Under 24 Hrs.                          | 8, Date of Birth                                       | 9. Bi                                 | rthplace (State or Foreign<br>ountry) |  |  |
| uneral   | 5.  | Social Security Number 6. Se   | ТМ 21XF  | Yrs. Months Days  | Hours Min.                                | (Month, Day, Ye.                                       |                                       | nnecticut                             |  |  |
| irector  | L   | 112-05-8751  | 90   |   |   | Jan. 9,  | 1918   60                             | miec croac_                           |  |  |
| >  | -   | sual Residence of Decedent  0a. State 10b. County  | 10c. City,   | Town or Location  |   |  |                                       | 10d. Inside City Limits               |  |  |
| dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at event, the Completed by Funeral Director |   | ou. Claid  |  |   |   |  |                                       | 1 Yes 2 □ No                          |  |  |
| Ba-f<br>Stiffe   | į l   | Maryland   | Montgomery   | Olney<br>10f. Zip Code  |   | 10g.   | Citizen of What C                     | country?                              |  |  |
| or 28a-f st<br>be notified<br>Director   | 1   | 0e. Street and Number  |  | USA   |   |  |                                       |                                       |  |  |
| ust l  | 5   | 4238 Briars Road   |  | 20832   | enanic Origin? (Sp                        |  | 14. Race - Arr                        | erican Indian,                        |  |  |
| iner must  | 1   | 1. Marital Status  | 12. Was Decedent Ever in U.S<br>Armed Forces?                | <ol> <li>Was Decedent of H<br/>If Yes, specify Cuba</li> </ol>                        | n, Mexican, Puerto                        | Rican, etc.)   | Black, Wh                             | ite, etc.                             |  |  |
| el E   |   | 1 Never Married 2 Married  | 1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates:             | 1 ☐ Yes 2 No  | Specify:                                  |  | Specify:<br>Whi                       | <b>+</b> 0                            |  |  |
| Exal<br>P  | 2   | 3 Widowed 4 □ Divorced   | . Kind of Busines  |   |   |  |                                       |                                       |  |  |
| t, the Medical E   |   | 15. Decedent's Ed<br>(Specify only highest grad  | de completed)  | 16a. Decedent's Usual Occup<br>(Give kind of work done of<br>life. DO NOT use retired | during most of work                       | ing  |                                       | •                                     |  |  |
| l du   | -   | Elementary/Secondary (0-12)  | College (1-4or 5+)   |   |   |  | Law                                   |                                       |  |  |
| غ ا  | 3 -   |  | 2  | Legal Sec   |   | e (First, Middle, Mai                                  |                                       |                                       |  |  |
| å  |   | 7. Father's Name (First, Middle, Last)   |  | 121   | lorence G                                 |  |                                       |                                       |  |  |
| F  | 2 _   | Gustav Kjeller   |  | 19b. Mailing Address (Street  |   |  | ity or Town State                     | Zin Code)                             |  |  |
| į  | -1  | 19a. Informant's Name/Relationship (7  |  |   |   | Olney, M   |                                       | , Elp Codo)                           |  |  |
|  |   | Joseph F. Leach/S  |  |   |   | 200  | c. Location - City                    | or Town State                         |  |  |
| y or other traumatic ever  | 2   | 20a. Method of Disposition<br>1√□ Burial 2 □ Cremation 3 🛣   | Removal from State   | lace of Disposition (Name of<br>emetery, crematory or other place                     | re) ¡Feb.                                 | 4,2008   | Calvert                               |                                       |  |  |
| 5  |   | 4 □Donation 5 □ Other (Specify   |  | lverton Nation  | al Cemete                                 | ry L   |                                       | nd, New Yor                           |  |  |
| any injury o   | T   | 21. Signature of Funeral Service Licen   | see  | 22. Name and Addre  | Calling                                   | Funeral  | Home Inc                              | •                                     |  |  |
| ono  | 1   | I forms C  | andreas  | 500 Univer  | sity Blv                                  | d, W, Sil  | ver Spri                              | ng, MD 2090                           |  |  |
|  | $\top$  | 23a. Part1. Enter the disease, or com  | plications that caused the death                             | n. Do not enter the mode of dyli  | ng, such as cardiac                       | or respiratory arrest                                  | 1                                     | Approximate<br>Interval Between       |  |  |
|  |   | shock, or heart failure. List only   | Pulman   | av edena  |   |  |                                       | Onset and Death                       |  |  |
| an<br>cal  |   | disease or condition resulting in death)   |  |   | 1   |  |                                       |                                       |  |  |
| er   |   | resulting in death)  Due to (or as a consequence of):  |  |   |   |  |                                       |                                       |  |  |
|  | <u>.</u>  | Sequentially list conditions,  | b. Due to (or as a consequence)                              | uence of):  |   |  |                                       |                                       |  |  |
|  | Examiner  | if any, leading to immediate Enter Under in Cause (Disease or injury that initiated events   |  |   |   |  |                                       |                                       |  |  |
| -  | xar   | that initiated events resulting in death) Last   |  |   |   |  |                                       |                                       |  |  |
|  | <u>e</u>  |  |  |   |   |  |                                       |                                       |  |  |
| -  | dical   |  | d  |   |   |  |                                       |                                       |  |  |
|  | Physician/Me  | IF FEMALE:   | 23c. If yes, outcome pf pregna                               |   | delivery                                  |  |                                       |                                       |  |  |
|  | ian   | 23b. Was decedent pregnant in the past 12 months?  |  | Month Day   |   |  |                                       |                                       |  |  |
|  | S   | 1 ☐ Yes 2. 2 No<br>9 ☐ Unknown   |  | ·   |   |  |                                       |                                       |  |  |
| i  | Ę.  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributions |  |   |   |  |                                       |                                       |  |  |
|  | ا ۾   |  | 2 <b>)</b> 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1             | 2 No 3 Probably 4 Unkno   |   |  |                                       |                                       |  |  |
|  | Completed   |  |  |   |   | 24a. Was an  | 24b. Were                             | autopsy findings availa               |  |  |
|  | ם   |  |  |   |   | autopsy<br>performe                                    | prior                                 | to completion of cause                |  |  |
|  | ్   |  |  |   |   | 1□ Yes 2   | 10                                    | /es 2□No                              |  |  |
|  | Be (  | 25. Was case referred to medical examiner?   |  | ath (Check only one)  |   |  |                                       |                                       |  |  |
|  | ၉   | 1 ☐ Yes 2. No  |  | ER/Outpatient 3 DOA   |   | lome 5 Residen   |                                       | Specify)                              |  |  |
|  |   | 27. Manner of Death  1. Natural 5 □ Pending  | 28a. Date of Injury<br>(Month, Day Year)                     | 28b. Time of lnjury 28c. Injury Wo  | uryat<br>ork?<br>]Yes 2∐No                | 28d. Describe nov                                      | injury occurred                       |                                       |  |  |
|  | atic  | 2 ☐ Accident investigatio  |  |   | 00/ 1 - 1/- /04-                          | 8f. Location (Street and Number or Rural Route Number, |                                       |                                       |  |  |
|  | Certification:  | 3 ☐ Suicide 6 ☐ Could not be determined  |  | ome, farm, street, factory, office fy)  | City or Town,                             | or Town, State)  |                                       |                                       |  |  |
| 2  | 29a. Certifier  128 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner |  |  |   |   |  |                                       |                                       |  |  |
|  |   | 29a. Certifier  (Check only  (Check only  2 ☐ Medical Example 1  | hysician: To the best of my knominer: On the basis of examin | owledge, death occurred at the<br>ation and/or investigation, in my                   | time, date and plac<br>opinion, death occ | e, and due to the ca<br>urred at the time, da          | use(s) and manne<br>te and place, and | due to the cause(s)                   |  |  |
| completely filled in by u  | ledical   | one)   | and manner stated.   |   |   |  | d. Date signed (N                     |                                       |  |  |
|  | ž   | 29b. Signature and title of certifier  | 1 1 1 21   |   | nse number                                |  |                                       |                                       |  |  |
|  |   | / lliv   | Her Ph   | YSTUTES   | 00556                                     |  | JEYVELY                               | 28, 2008                              |  |  |
| }  |   | 30. Name and address of person who   | completed cause of death (Ite                                | m 23a) (Type, Print)  |   | 6.1  |                                       | 7 5                                   |  |  |
|  |   | 1.4  | MATHUZ   | 4000 Rt   | 108                                       | Olacy, t   | 1D 208                                | 5 2                                   |  |  |
| Sta  | te  | 31. Date filed (Month, Day, Year)  | an Delictronia Cina  | B. Sperti   |   |  |                                       |                                       |  |  |
| (2) (3)  |   | JAN 30   | 2008 Magner  | EL Magalia I  |   |  |                                       |                                       |  |  |
| Registra   | ar  | JAN 5 V  | COOL REPURE  | 10. When  |   |  |                                       |                                       |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 0/35A M Denise M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Battimore University Maryland Medical Centra 01 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Days 1 M 2 F 219-84-5531 36 Nov.19.1971 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medica Examiner must be notified at 1 XYes 2 No Director Maryland **Annapolis** Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number e filed within 72 hours after death with tal Hygiene. 30 Heritage Court 21401 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bakery 12 Crew Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental Hi ant: If item 27 Is marked oth Frank Laki Gavle Clough ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: if item 27 Is
any Injury or other trau 416 Fox Hollow Lane, Annapolis, MD Gayle Bender / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Mem.Gardens 1/30/08 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hedatitis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical as been signed by the attending should be detached for use as IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by **¥ □ Únknown** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 2 □ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2□ No 1 Impatient Yes 2 ER/Outpatient 3 DOA Medical Certification: To Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Atural 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 25. 2208 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 225 Greene Bactimore MD MD 31. Date filed (Month, Day, Year) JAN 29 32. gistrar's Signature 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 5:15 P 25, 2008 Mildred Mooney Lusby Jan. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days 1□M 2**X**F 79 21, 1928 Maryland 212-24-4043 Feb. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Severna Park Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21146 USA 22 Boone Trail Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify. Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Courtney Howard Mooney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1047 Wrighton Road Lothian, Maryland 20711 William C. Lusby/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 30, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. Ft. Lincoln Cemetery Brentwood, Maryland 2008 21. Synatur Funeral Service Licensee 22. Name and Address of Facility
Barranco & Sons P. Park Funeral Home Park, MD 21146

29d. Date signed (Month, Day, Year)

Au Charles 21619

3 Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

MD

Director

by Funeral

Completed

Be

ဥ

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

nding physician and funeral director, Medical Certification: To Be s after death. filled in by

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician/Medical Examiner

Completed by

29a. Certifier

31. Date filed (Monti

29b. Signature and title of certifi

| 479m85 (0 1   | 1 mosson  | 495 Gov               | . Ritchie H   | wy, Severna                    | Park,            | MD 21       | 146                                   |  |  |  |
|---|---|-----------------------|---|--------------------------------|------------------|-------------|---------------------------------------|--|--|--|
| 27a. art1 Enter the disease, or comp<br>shork, or heart failure. List only              | lications that caused the death. Do one cause on each line.                                     | not enter the mode    | of dying, such as cardiac   | or respiratory arrest,         |                  | Interv      | oximate<br>val Between<br>t and Death |  |  |  |
| Immoriate Cause (Final ease or condition  | a Borberid Sasi Arm bladdon   |                       |   |                                |                  |             |                                       |  |  |  |
| resulting in death)   | Due to (or as a consequence   |                       |   |                                |                  |             |                                       |  |  |  |
| Sequentially list conditions, if any, leading to immediate tause. Enter Inderlying      | b. Due to (or as a consequence  | ,                     |   |                                |                  |             |                                       |  |  |  |
| Cause (Disease or injury that initiated events resulting in death) Last                 | C   |                       |   |                                |                  |             |                                       |  |  |  |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Ro 9 □ Unknown | 23d. Date of do<br>Month  |                       |   |                                |                  |             |                                       |  |  |  |
| Part II. Other significant conditions of  | ontributing to death but not resulting  | in the underlying car | use given in Part I.  | 23e. Did tobacc                | o use contribute | to the caus | se of death?                          |  |  |  |
|   |   |                       |   | 1 □ Yes                        | 2 <b>№</b> 0 3□F | robabiy     | 4 □Unkno                              |  |  |  |
| X   |   |                       |   | 24a. Was an autopsy performed? | ? death?         | completic   | on of cause of                        |  |  |  |
| 25. Was case referred to medical  | 26. Place of Death (Check only one)   |                       |   |                                |                  |             |                                       |  |  |  |
| examiner?<br>1 ☐ Yes 2 ☐ No   | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) |                       |   |                                |                  |             |                                       |  |  |  |
| 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation                       | 28a. Date of Injury (Month, Day Year) 28b.  |                       | dc. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No  | 28d. Describe how in           | jury occurred    | curred      |                                       |  |  |  |
| 3 Suicide 6 Could not be<br>4 Homicide determined                                       | 28e. Place of injury - At home, f<br>building, etc. (Specify)                                   | arm, street, factory, | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |                                |                  |             |                                       |  |  |  |

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2008

DHMH 17 Rev 1/2001

State

Registrar

within 24 hours at To the Funeral D

**ORIGINAL** 

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** JANUARY 2008 9:04 AM MARTIN BURNETT LYONS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner EASTON TALBOT 30588 KINGSTON ROAD 8. Date of Birth (Month, Day, Year)

JUL 31, 1920 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours Months 87 MARYLAND 216-10-9171 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show notified at 1 ☐ Yes 2 ☐ No Director EASTON MD TALBOT permit. Pages 1 and 2 should be filed within 72 hours after death with the N. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "notice." 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 30588 KINGSTON ROAD 21601 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X**If Yes, Give
Year or Dates: 1X Never Married 2 Married 2**X** No 1 ☐ Yes 2 ☐ No Specify. þ Specify: WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AGRICULTURE 11 0 FARMER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ESTELLE FRIST HARRY H. LYONS ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) H. LAWRENCE LYONS/NEPHEW 8630 MT. HOPE ROAD, CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY 1/29/2008 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Ostrowshi C.F.SF 21. Joseph 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cardine dyschuthonio /Medical Due to (or as a consequence of): Examiner athroscleronc x years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 I Inknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown per, pheral vascular diseuse Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an huper tension autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director; / 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier anuary 24, 2008 sumour M 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Id Avenue, Easten MD ymow me 31. Date filed (Month, Day, Year) State JAN 2 5 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 4:15 PM Donald Norman lalone 23 01 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner university of maryland med conter Bultimore, MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 6 Sex 5. Social Security Number **Funeral** Days Hours Min. 1**X**M 2□F APR 30, NEW YORK 80 Director 087-20-4366 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes X No Director MD CAROLINE PRESTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21166 MARSH CREEK ROAD 21655 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Specify: If Yes, Give Year or Dates: <u></u> 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FARM EQUIPMENT 12 12 should be filed wing and Mental Hygier 12 is marked other th SERVICE MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NORMAN LALONE MYRTLE WHITE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once. HELEN LALONE/WIFE 21166 MARSH CREEK ROAD, PRESTON, MARYLAND 21655 20b. Place of Disposition (Name of cemetery, crematory or other place)
WEST LOWVILLE 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State LOWVILLE, NEW YORK 05/01/2008 4 ☐ Donation 5 ☐ Other (Specify) RURAL CEMETERY 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 C.F.S.P Jokep 4 31. Ustrough. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septic Shock /Medical Due to (or as a consequence of): day **Examiner** amputation stump Knee Interted alarve Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit that the death certificate be executed Acute bypuss graf thrombosis Due to (or as a consequence of) P.O. Box 68760 Physician/Medical vascular Des pheral the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by certery disease, Ischemic NG Yes 2 No 3 Probably 4 Unknown Hypertensia, Hyperlipidemia, Ventricular 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has birector, page 2 s autopsy perform 25. Was case referred to medical examiner? 1 2 No 1 Yes 2 No director, 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA Inpatient 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death after death. (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide ö within 24 hours a 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie AU4176435A17337 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2+ VA 122 S. Greene Sti Bultimore MD, 21201 Abouzied, MI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Eleve & good Registrar DHMH 17 Rev 1/2001

|                |  |                  | 1 = For State Ragistrar  | State of Ma                             | aryland            |                                   | irtment<br><i>tificate</i>              |              |   |                              | giene2  <br>Reg. No. | 008                     | 04183                           | 3  |
|----------------|--|------------------|--|---|--------------------|-----------------------------------|---|--------------|---|------------------------------|----------------------|-------------------------|---------------------------------|----|
|                | Dhysisi  |                  | 1. Decedent's Name (First, Middle, Las   |   |                    |                                   |   |              |   | 2. Date of De.<br>Month      | ath<br>Day           | Year                    | 3. Time of Death                |    |
|                | Physicia<br>/Medic   |                  | EMILY FLORENCE   |   | 16                 |                                   |   |              |   | 01                           | 26                   | 2008                    | 1040M                           | _  |
|                | Examin   | er               | 4a. Facility Name (If not institution, give  | -                                       |                    |                                   | 4b. City, T                             | own, or Lo   | cation of Death   |                              |                      | nty of Death            |                                 |    |
|                |  |                  | 28 KWANZAN   |   |                    |                                   |   |              | OWN   | 0 D (D:-                     |                      | ARRO                    |                                 | _  |
| П              | Funeral  |                  | 5. Social Security Number 6. So  | ox 7. Ag<br>□M 2□XF                     | e (In yrs. Ia<br>G | st birthday)                      | If Under 1<br>Months                    |              | Under 24 Hrs.<br>Hours Min.                               | 8. Date of Bin<br>(Month, Da | y, Year)             | Cour                    | lace (State or Foreign<br>htry) |    |
|                | Director   |                  | 217-26-3501 Usual Residence of Decedent  |   | 7                  | /                                 |   |              |   | 08/2                         | 0/1908               | Mary                    | Land                            | _  |
|                | land   |                  | 10a. State 10b. County   |   | 10c. City,         | Town or Lo                        | cation                                  |              |   |                              |                      | 1                       | 0d. Inside City Limits          | _  |
|                | Mary   | 호                | MD Carroll   |   | Tana               | ytown                             |   |              |   |                              |                      |                         | 1 XYes 2 ☐ No                   |    |
|                | the  | rec              | 10e. Street and Number   |   | Tanc               | y cowii                           | 10f. Zip (                              | Code         |   |                              | 10g. Citizen         | of What Cour            | ntry?                           | _  |
|                | 3a o   | 0                | 28 Kwanzan Street  |   |                    |                                   | 2178                                    | 37           |   |                              | USA                  |                         |                                 |    |
|                | filed within 72 hours after death with the Maryland<br>Hygione.<br>ther than "natural", or Itema 23a or 28a-f ahow<br>int, I'ra Madical Examinar must be notitled at | Funeral Director | 11. Marital Status   | 12. Was Decedent<br>Armed Forces?       | Ever in U.S        | 5. 13. V                          | Vas Decede                              | ent of Hispa | anic Origin? (Sp<br>Mexican, Puerto                       | ecify Yes or No              |                      | lace - Americ           |                                 |    |
| ٥              | or Ite   |                  | 1 Never Married 2 Married  | 1 ☐ Yes 2 🛣                             | No                 |                                   | Yes 2                                   |              | Specify:  | Tribari, Gro.,               | Spe                  |                         |                                 |    |
| 2-0036         | irel',   | d by             | 3 ☐ Widowed 4 🎇 Divorced   | Year or Dates:                          |                    |                                   |   |              |   |                              |                      | Wnli                    |                                 | _  |
| ਨ<br>ਨ         | 72 h<br>natu   | Completed        | 15. Decedent's Ed<br>(Specify only highest gra-                                    |   |                    | 16a. Deced                        | kind of work                            | done duri    | n<br>ing most of work                                     | ing                          | 16b. Kind of         | Business/Inc            | dustry                          |    |
| 7              | hen.   | ш                | Elementary/Secondary (0-12)  | College (1-4or 5                        |                    | me. L<br>Homema                   | OO NOT use                              | relired)     |   |                              | Own Ho               | ma                      |                                 |    |
| N              | Hygie<br>other t   |                  | 17. Father's Name (First, Middle, Last)  |   |                    | пошеша                            | ikei_                                   | 18           | . Mother's Name   | e (First, Middle,            |                      |                         |                                 | -  |
| Maryland       | od of o  | Be               | William Livingstor   | 1                                       |                    |                                   |   |              | arriet E  |                              |                      |                         |                                 |    |
| $\tilde{\leq}$ | hould<br>d Me<br>mark<br>matic   | ဥ                | 19a. Informant's Name/Relationship (7  |   |                    | 19b. Mailin                       | n Address                               |              | Number or Run   |                              |                      |                         | Code)                           | -  |
| <u> </u>       | id 2 she<br>Ith and<br>27 le m<br>traum  |                  | Jean P. Smorse/day   |   |                    |                                   |   |              | eet Tane  |                              |                      |                         |                                 |    |
| ē,             | s 1 and<br>if Health<br>Item 27<br>other tr  |                  | 20a. Method of Disposition   |   | 20b. Pla           | ace of Dispo:                     | sition (Name                            | e of         | 1   | Date                         | 20c. Locatio         | n - City or To          | own, State                      | -  |
| Ē              | 0 0 = = [  |                  | 1 ☐ Burial 2 XCremation 3 ☐<br>4 ☐ Donation 5 ☐ Other (Specify                     |   | -                  | <sub>metery, crem</sub><br>sapeal | -                                       |              | ry 01/3   | 80/08                        | Beltsv               | ille,                   | MD                              |    |
| altimore,      | 그 등문을  |                  | 21. Signature of Funeral Service Licen   | ,                                       | 1                  |                                   |   |              | Facility<br>Crematic                                      |                              | iac P                | O Box                   | v 78/1                          | -  |
| ă              | Depending Impo   |                  | 130:00 ly L.   | Helt                                    | MO12               |                                   |   |              |   |                              |                      |                         | e, MD 2102                      | g  |
|                |  |                  | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only       | olications that caused                  | the death.         |                                   |   |              |   |                              |                      |                         | Approximate<br>Interval Between | ** |
|                | Physician  |                  | Immediate Cause (Final   | //                                      |                    | : /.                              | 4 = 4 4                                 | 1.           |   |                              |                      |                         | Onset and Death                 |    |
| Ì              | /Medical   |                  | disease or condition resulting in death)   | a. Due to (or as                        | ence of):          | cart                              | fai                                     | ension       |   |                              |                      |                         | -                               |    |
|                | Examiner   |                  |  | - Puls                                  | mana.              | ALA 1-                            | hers                                    | nense        | msion   |                              |                      |                         |                                 |    |
| -              |  | Je.              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as                           | a conseque         | ence of)                          | 1                                       |              | , , , , , ,   |                              |                      |                         |                                 |    |
|                | cuted<br>nd<br>ransl   | Examin           | that initiated events  | с                                       |                    |                                   |   |              |   |                              |                      |                         |                                 |    |
| Š              | e exe<br>ien a<br>urial-l  | Ä                | resulting in death) Last   | Due to (or as                           | a conseque         | ence of):                         |   |              |   |                              |                      |                         |                                 |    |
| 8/PU           | cate be executed<br>physicien and<br>the burial-transit  | dlcal            | •  | d                                       |                    |                                   |   | -            |   |                              |                      |                         |                                 | -  |
| ٥              | entific<br>ling p  | Mec              | IF FEMALE:   | 00- 14                                  | a weed             |                                   |   |              |   |                              |                      |                         |                                 | _  |
| X<br>Q<br>Q    | death certifi<br>e ettending  <br>ed for use as  | lan/             | 23b. Was decedent pregnant in the past 12 months?                                  | 23c. If yes, outcome<br>1□Live birth    | 2 Fetal            | death 3                           | Ectopic pre                             |              |   |                              |                      | Date of delive<br>Month | ery<br>Day Year                 |    |
| -<br>-         | that the death certifi<br>ed by the ettending I<br>detached for use as   | Physician/Me     | 1 ☐ Yes 2 X No<br>9 ☐ Unknown  | 4 Pregnant at<br>9 Unknown              | time of dea        | ath 5⊔                            | Other (spe                              | city)        |   |                              |                      |                         |                                 |    |
|                | requires that the<br>een signed by th<br>hould be detache  |                  | Part II. Other significant conditions of   | entributing to death b                  | ut not resul       | ting in the ur                    | derlying ca                             | use given i  | n Part I.   | 23e. Did t                   | obacco use c         | ontribute to ti         | he cause of death?              | _  |
| Š,             | 8 6 8  | d b              |  | 3                                       |                    | •                                 | , ,                                     | 3            |   | 10                           | Yes 2 □ No           | 3 Prob                  | pably 4 🗹 Unknown               |    |
| Hecords        | w require<br>been si<br>should   | Completed        |  |   |                    |                                   |   |              |   | 24a. Was                     | 24                   | h More auto             | psy findings available          | _  |
| ě              | hes<br>pe 2  | 립                |  |   |                    |                                   |   |              |   | auto                         |                      | prior to co<br>death?   | mpletion of cause of            |    |
|                | iclan: The certificate herector, page  |                  |  |   |                    |                                   | <u>-</u>                                |              |   | 1 ☐ Yes                      | 2 X No               | 1 🗆 Yes                 | 2 □ No                          |    |
| Vital          | Physician:<br>this certific<br>ral director,   | o Be             | 25. Was case referred to medical examiner?   | Hospital:                               |                    | .D/O                              | • | Othor        | <ol> <li>Place of Deat</li> <li>4 ☐ Nursing Ho</li> </ol> |                              |                      | Dthan (Canad            |                                 | -  |
| ö              | Phys<br>rthis<br>ral di  | -                | 1 Yes 2 No  27. Manner of Death  | 1 ☐ Inpatie                             |                    | R/Outpatien<br>28b. Time of       |   | c. Injury at |   | 28d. Describe                |                      |                         | y)                              | -  |
| 0              | ding<br>th:<br>Afte  | 후                | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation                                | (Month, Day                             | Year)              | Injury                            | м                                       | Work?        | 2 No  |                              |                      |                         |                                 |    |
| DIVISION       | r Attending P<br>er death.<br>rector: After<br>by the funera   | ‡ Ça             | 3 ☐ Suicide 6 ☐ Could not be   | 28e. Place of Inj                       |                    |                                   | et, factory,                            | office       |   | 28f. Location (              | Street and Nu        | mber or Rura            | al Route Number,                | -  |
| É              | efter<br>Dire  | Certification:   | 4 ☐ Homicide   | building, et                            | c. (Specify)       |                                   |   |              |   | City or To                   | wn, State)           |                         |                                 |    |
|                | To the Hospitat or Attend within 24 hours efter death To the Funerel Director: completely filled in by the to  | la<br>O          | 29a. Certifier 1 Certifying Ph   | sician: To the best                     | of my know         | rledge, death                     | occurred a                              | t the time,  | date and place,   | and due to the               | cause(s) and         | manner as s             | tated.                          | _  |
|                | n 24<br>he Fu  | edical           | (Check only 2 Medicat Examone)   | iner: On the basis of<br>and manner sta |                    | on and/or inv                     | estigation,                             | in my opini  | on, death occur   | red at the time,             | date and plac        | e, and due to           | o the cause(s)                  | _  |
|                | To t<br>Withi<br>Comp  | Ž                | 29b. Signature and title of certifier  |   |                    |                                   | 29c.                                    | License nu   | umber   |                              | 29d. Date sig        | ned (Manth,             | Day, Year)                      |    |
|                |  |                  | Datubus  | MO                                      |                    |                                   | D                                       | 006          | 5201  |                              | 01/28                | 3/08                    |                                 |    |
|                |  | - 1              | 30. Name and address of person with  | ompleted cause of d                     | eath (Item :       | 23a) (Type, I                     | Deint\                                  |              |   |                              |                      | ,                       |                                 |    |
| 1              | 161  | i                |  |   |                    |                                   | -tirit)                                 |              |   |                              | -                    |                         |                                 | ,- |
| 0              | LEG  |                  | BONNIE FIT   | LEBERG,                                 |                    | 719                               | D C                                     | REST         | WOOD  | BLUD                         | FRED                 | ERICK                   | MD 2170                         | 2  |

State of Maryland / Department of Health and Mental Hygiene

1 Stata

Certificate of Death

04/84

**Physicia** /Medica Examine

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Itema 23a or 28a-f ahow any Injury or other traumatic event, tra Medical Examples inval be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

|       |                | negistrar   |                                       |                               |                     | 001                    | imodic or                               | Douin                      |                         | reg. No.                 |                           |   |
|-------|----------------|---|---------------------------------------|-------------------------------|---------------------|------------------------|---|----------------------------|-------------------------|--------------------------|---------------------------|---|
| sici  | an             | Decedent's Name   |                                       |                               | M                   |                        |   |                            | 2. Date of Dea<br>Month | Day                      | Year                      | 3. Time of Death                                |
| edic  |                | 4a. Fecility Name (II   |                                       | Michael P                     |                     | iller                  | 4h City Town                            | or Location of De          | Februar                 | 7                        | 2008<br>ounty of Death    | 2225 P <sup>M</sup>                             |
| ımin  | er             | Booth II  |                                       |                               | 20.7                |                        | Risin                                   | _                          | 201                     |                          | Cecil                     | •   |
| eral  |                | 5. Social Security N  |                                       | Sex 7                         | . Age (In yrs.      | last birthday)         | If Under 1 Year                         | If Under 24 H              | s. 8. Date of Birth     | h                        | 9. Birth                  | place (State or Foreign                         |
| tor   |                | 222-38-00   | 073                                   | 1 <b>X</b> M 2□ F             | 72                  | Yrs.                   | Months Days                             | Hours Mi                   | DEC 11,                 | 1935                     | Ne                        | w York  |
|       |                | Usuel Residence of<br>10a. State                                      | Decedent<br>10b. County               |                               | 100 Ci              | ty, Town or Lo         | ention                                  |                            |                         |                          |                           | 10d Inside City Limite                          |
|       | J.             |   |                                       |                               |                     |                        |   |                            |                         |                          |                           | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No          |
|       | Director       | Maryland  10e. Street and Nur   | Cecil                                 |                               | 1 1                 | North E                |   |                            |                         |                          |                           |   |
|       | 급              |   |                                       | - 11:-1                       |                     |                        | 10f. Zip Code                           |                            |                         |                          | n of What Cou             | •   |
|       | erai           | 11. Marital Status  | epn bigg                              | s Highway                     |                     | IS 13 V                | 21901                                   | dispanic Origin?           | (Specify Yes or No-     |                          | ited St<br>Race - Amer    |   |
|       | Funerai        |   | ed 2)() Married                       | Armed Ford                    | ces?                |                        | Yes, specify Cub                        | an, Mexican, Pu            | erto Rican, etc.)       |                          | Black, White              |   |
|       | ρ              | 3 Widowed   | 4 Divorced                            | If Yes, Give<br>Year or Da    | )                   |                        | I□Yes 2X No                             | Specify:                   |                         | Sp                       | pecify: Wh:               | ite   |
|       | eted           | (Spec   | 15. Decedent's                        | Education<br>grade completed) |                     | 16a. Deced             | lent's Usual Occup                      | pation<br>during most of w | ndrina                  | 16b. Kind                | of Business/I             |   |
|       | Completed      | Elementary/Secon  |                                       | College (1-                   | 4or 5+)             | life. I                | OO NOT use retire                       | d)                         | O. Kang                 | Depa                     | artment                   | t of  |
|       | ပိ             | 12  | · · · · · · · · · · · · · · · · · · · |                               |                     | La La                  | borer                                   |                            |                         |                          |                           | esources  |
|       | Be             | 17. Father's Name (   |                                       | st)                           |                     |                        |   |                            | ame (First, Middle,     | Maiden Su                | mame)                     |   |
|       | ၉              | Peter Mil   |                                       | (Type Print)                  |                     | 105 Maille             | - A dd (C4                              | Kather                     |                         | . 0                      | Ot-4- 7                   | 7- O-d-1  |
|       |                | Julie Mod   |                                       |                               |                     |                        |   |                            | Rural Route Numbe       |                          |                           |   |
|       |                | 20a. Method of Disp   |                                       | nter                          | 20b. F              | Place of Dispo         | sition (Name of                         |                            | shway, Non              |                          | tion - City or 1          |   |
|       |                |   | Cremation 3<br>5 ☐ Other (Spec        | ☐Removal from S               | tate                |                        | natory`or other pla<br>s & Co., I       |                            | cuary 8,                |                          |                           | er, PA  |
|       |                | 21. Signature of Fu   |                                       |                               | 10.                 |                        |   |                            | -                       | MEST                     | Cliest                    | er, in  |
| once  |                | J. J.   | sto To                                | 1.10                          |                     | Hi                     | cks Home                                | for Fu                     | nerals, P               | . A .                    | MD 01                     | 001   |
|       | 7              | 23a. Part1. Enter th  | e disease, or co                      | mplications that ca           | used the deat       | th. Do not ent         | or the mode of dyi                      | ng, such as cardi          | reet, Ell               | rest,                    | MD 21                     | Approximate                                     |
| an    |                | Immediate Cause (   | Final                                 | ly one cause on ea            | 1                   | 0 .                    | Ca                                      |                            | _                       |                          |                           | Interval Between<br>Onset and Death             |
| cal   |                | disease or condition resulting in death)                              | 4                                     | a<br>Due lo (o                | r as a conseq       |                        | Cec                                     | VI CE                      | 1                       |                          |                           | 42  |
| ner   |                | Commentate the time of  | - Catalana                            | h                             |                     |                        |   |                            |                         |                          |                           |   |
|       | ner            | Sequentially list cor<br>cause. Enter Under<br>Cause (Disease or i    | riving                                | Due to (o                     | r as a conseq       | (uandá uf):            |   |                            |                         |                          |                           |   |
|       | Examiner       | Cause (Disease or i<br>that initiated events<br>resulting in death) L |                                       | c                             |                     |                        |   |                            |                         |                          |                           |   |
|       |                | resulting in death) c   | .ast                                  | Due to (o                     | ras a conseq        | (uence of):            |   |                            |                         |                          | 1                         |   |
|       | dica           |   |                                       | d                             |                     |                        |   |                            |                         |                          | -                         |   |
|       | an/Medicai     | IF FEMALE:  |                                       | 23c. If yes, outco            | ome of pregna       | ancv                   |   |                            | -                       |                          | . Data of dall            |   |
|       |                | 23b. Was decedent<br>in the past 12                                   | months?                               | 1 ☐ Live bir                  | th 2 ☐ Fete         | ol death 3             | Ectopic pregnanc<br>Other (specify)     | 1                          |                         | 230                      | I. Date of deli-<br>Month | very<br>Day Year                                |
|       | ysk            | 1 ☐ Yes 2 ☐<br>9 ☐ Unknown  | JNo                                   | 9□ Unknov                     |                     | - J                    | Cities (specify)                        |                            |                         |                          |                           |   |
|       | by Physic      | Part II. Other signifi  | cant conditions                       | contributing to dea           | ith but not res     | sulting in the ur      | iderlying cause gr                      | en in Part I.              | 23e. Did to             | bacco use                | contribute to             | the cause of death?                             |
|       | 8              |   |                                       |                               |                     |                        |   |                            | 102                     | 95 2 N                   | 10 3 Pro                  | bably 4 Unknown                                 |
|       | plet           |   |                                       |                               |                     |                        |   |                            | 24a. Was a              | an 2                     | 4b. Were au               | topsy findings available                        |
|       | Completed      |   |                                       |                               |                     |                        |   |                            | autop<br>perfor         | med?                     | death?                    | topsy findings available completion of cause of |
|       | Be             | 25. Was case referr   | red to medical                        |                               |                     |                        | *************************************** | 26. Place of D             | eath (Check only or     |                          |                           |   |
| ,     | 욘              | 1 Yes 2 2   |                                       |                               |                     | ER/Outpatien           | 3 DOA Ott                               | er: 4 🗌 Nursing            | Home 5 Resid            | ence 6 🛚                 | Other (Spec               | assisted  |
|       | ë              | 27. Manner eath   | 5 ☐ Pending                           | 28a. Date of<br>(Month)       | Injury<br>Day Year) | 28b. Time of<br>Injury | 28c. Injui                              |                            | 28d. Describe h         | ow injury o              | ccurred                   |   |
|       | cat            | 2 ☐ Accident<br>3 ☐ Suicide   | investigati                           | he                            |                     |                        |   | Yes 2 □ No                 |                         |                          |                           |   |
|       | Certification: | 4 🗌 Homicide  | determine                             | d 28e. Place o                | g, etc. (Specif     | ome, tarm, stre<br>fy) | eet, factory, office                    |                            | City or Tow             | treet and N<br>n, State) | umber or Hu               | ral Route Number,                               |
|       |                | 29a. Certifier  | 1/ Certifying F                       | Physician: To the h           | est of my kno       | wiedne death           | occurred at the ti                      | ne, date and pla           | ce, and due to the c    | 20100/0/ 20              | d manner as               | stated  |
|       | Medicai        | (Check only one)  | 2 Madical Ex                          | miner: On the bas             | is of examina       | ition and/or inv       | estigation, in my o                     | pinion, death oc           | curred at the time, of  | date and pla             | ice, and due              | to the cause(s)                                 |
|       | Me             | 29b. Signature and  | title of certifier                    | )                             |                     |                        | 29c. Licens                             | e number                   | 2                       | 29d. Date s              | ignéd (Mon/h              | , Day, Year)                                    |
|       |                | OL  |                                       | >-                            |                     | ill                    | D DO                                    | 056                        | 449                     | 2                        | 18/2                      | 78  |
|       |                | 30 Name and addre   | ss of person wh                       | o completed cause             | of death (Iten      | n 23a) (Type,          | Print) /                                | 10                         | 4 2                     | . 110                    | ,                         |   |
|       | 1              | ploria  | Simon                                 | son/M                         | 0/11                | West                   | High                                    | X. Sui                     | le 502 (                | SIKT                     | an M                      | D2197   |
| Stat  |                | 31. Date filed (Monti   |                                       | 2008 32.76                    | gistrar's Signa     | ature /                | ast I                                   | ,                          |                         |                          |                           |   |
| istra | ir             | -   | FR I 3                                | ZUU0   1                      | Sister de           | A. Jak                 | and and                                 |                            |                         |                          |                           |   |

Registrar

FEB 1 3 2008

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** Jack Owen McGreevy FEBRUARY 4. 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WMHS - MEMORIAL CAMPUS Cumber 1 and
If Under 1 Year | If Under 24 Hrs. Allegany Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Months Davs Hours Min 1X M 2□F 27,1939 Director 68 Keyser, WV 234-62-4032 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show 10a. State r 28a-f show notified at 1 X Yes 2 No Funeral Director Mineral Keyser 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number death with "natural", or Items 23a or 335 Fort Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: unknown 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Machine Tender Paper Mill permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Owen John McGreevy Nellie Rebecca Newhouse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda L. McGreevy/ Wife 335 Fort Avenue Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Feb. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Queen's Point Cemetery 2008 Keyser, WV 22. Name and Address of Facility 21. Signature of Funeral Service License Smith Funeral Home 26726 85 S. Main Street Keyser, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CHRONIC OBSTRUCTIVE PULNONARY DISEASE disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4□Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown KIDNEY DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 2 No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 No 2 ER/Outpatient 1 ☐ Yes 1 Inpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) Injury 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOCIDO 08 HOAYI M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Seton DR., COMBERLAND MD AJAYI, M.D. 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Margaret Virginia Melito 1:35p January 28, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Collingswood Nursing & Rehab. Rockville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2X□ F Yrs. 1912 Washington, DC 95 July 21, Director 578-07-3459 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene. Instit If item 27 is marked other than "natural", or items 23a or 28a-f show that of high train and the houtlined at any or other traumatic event, the Medical Examiner must be notified at any or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ XNo Directo Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 4733 Wyaconda Road 20852 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ ¥₩Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Housing Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Jones Barney Rosenbaum ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4733 Wyaconda Road, Rockville, MD 20852 Constance M. Trapani/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 1
Department of H
Important; If ite
any injury or oth 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 1, Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008\_ Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Dreumont a Wation **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 s autopsy 2. No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3☐ Suicide determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica dempletely filled in by the funeral director, p

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) i 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Medical

State

29c. License number

DE062435

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50

31. Date filed (Month, Day, Year) 30

Registrar DHMH 17 Rev 1/2001

State

Rebecce ME Millian 1/24/08 0140

eted cause of death (Item 23a) (Type, Print)

gistrar's Signature

M.D.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

6 Could not be determined

Natasha Haag

30

31. Date filed (Month, Day, Year)

JAN

3□ Suicide

29a. Certifier

29b. Signature

Medical

4 Homicide

🗓 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

8600 Old Georgetown Road, Bethesda, MD 20814

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1/24/08

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 10:48 pM Olga D. Madiou 2008 January 24 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery 1771 Elton Road Silver Spring Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1 □ M 2 🖺 F 76 January 24,1932 Director 083-56-0046 Haiti Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location i and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Exa<u>miner must be notified at</u> 10a. State 1 ☐ Yes 2 No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. Funeral 1771 Elton Road death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced Black. Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Practice 12 Practical Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe ပ္ Clerisse Fontaine traumatic Joseph Ascar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a Department of Health an Important; If item 27 is any injury or other trau once. 10102 Phoebe Lane, Adelphi, Maryland 20783 Anthony N. Madiou - Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
George Washington 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify). 02/02/2008 Adelphi, Maryland Memorial Park 21. Signature of Funeral Service Ucense 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or peart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stage 4 Metastatic Uterine Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed for use as the burial-tranand Due to (or as a consequence of): P.O. Box 68760 attending physician IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, signe be c þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Pneumonia Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Diabetes Mellitus page 2 s autopsy certificate 1☐ Yes 2K No Pulmonary Embolism To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🕱 No 2 ER/Outpatient 3□ DOA 1 | Inpatient Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 TYes 2 TNo nours after death.
neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 25, 2008 D42135 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dany Westerband, M.D., 11119 Rockville Pike, Rockville, Maryland 20852 (Suite G-100)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN

32. Pagistrar's Signature

2008

30

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician**  $a^{\ M}$ 8:15 26, 2008 4c. County of Death Muriel McElvaney /Medical January 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 21913 Ruby Drive Boyds Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Director 003-03-1365 88 Jan. 20, 1920 Massachusetts Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No by Funeral Director Maryland | Montgomery Boyds 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 21913 Ruby Drive 20841 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after all Hygiene. I other than "natural", or iter 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: 3 ☐ Widowed 4 ☑ Divorced Caucasian Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Psychologist Counseling 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ ို Louis Baker Emily Jack 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum once. Claudia McElvaney - Daughter 1608 Reed Road, Knoxville, Maryland 21758 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Bunal 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory Ft. 1/31/2008 Brentwood, Maryland 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center
1040 Rockville Pike, Rockville, Maryland 20852 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Obstructive Pulmonary Disease 5 yrs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-tran and Due to (or as a consequence of): Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Year Month Day 5 ☐ Other (specify) Division or Vital Records, P.O. sate has been signed by the a page 2 should be detached in 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Adenocarinoma - Lung Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension 1 ☐ Yes 21 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 ☐ Yes 2 ▼ No 1 | Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008. 0015060 ter S. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter S. Birk, 10829 Georgia Avenue, #t-2, Silver Spring, Maryland MD 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |                | For State  | State o                                | f Marylan  | -                      | artment of   |  | d Mental Hy                                 | giene,                     | 2008                                       | 04190  |  |
|--|----------------|--|--|--|------------------------|--|--|---|----------------------------|--|--|--|
|  |                | RegIstrar     Decedent's Name (First, Middle)  | e, Last)                               |  |                        |  |  | 2. Date of D                                | eath                       |  | 3. Time of Death   |  |
| Physicia   |                | Florence   | Olivia                                 | McAt   | ee                     |  |  | Jan.  | 22, <sup>Day</sup>         | 08 Year                                    | 4:37p M  |  |
| /Medio   |                | 4a. Facility Name (If not institution  | -                                      |  |                        |  | or Location of De                      | eath  | 4c. C                      | ounty of Death                             |  |  |
|  |                | 15100 Interl   |  |  |                        |  | r Sprin                                |   |                            | ntgom                                      |  |  |
| Funeral<br>Director  |                | 5. Social Security Number 579-32-5944  | 6. Sex<br>1 ☐ M 2 🔀 F                  | 7. Age (In yrs. i  | last birthday)<br>Yrs. | If Under 1 Year<br>Months Day                                    |  | 1rs. 8. Date of B<br>lin. (Month, D<br>11/2 | irth<br>2 / 1 9 2          | 9. Birth<br>Cou                            | place (State or Foreign<br>intry)<br>PA                      |  |
| ie Maryland<br>Ba-f show<br>tified at  | Director       | Usual Residence of Decedent  10a. State 10b. County MD Montg   | omery                                  |  | y, Town or Lo          | Spring   |  |   |                            |  | 10d. Inside City Limits<br>1 ☐ Yes 2 💆 No                    |  |
| 3a or 2  | l Dire         | 10e. Street and Number<br>15100 Interl   | achen Dr                               | . #324   | 1                      | 10f. Zip Code<br>2090  |  |   |                            | en of What Cou<br>JSA                      | intry?   |  |
| permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: I flem 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | d by Funeral   | 11. Marital Status  1 □ Never Married 2 □ Marr  3 ☑ Widowed 4 □ Divorced   | ied 1 ☐ Yes<br>If Yes, Gi<br>Year or D | ve   | į                      | If Yes, sp <i>e</i> cify Co<br>1 □ Yes 2 <b>⊠</b> N              | uban, Mexican, Pu<br>o <i>Specify:</i> | (Specify Yes or N<br>uerto Rican, etc.)     | 5                          | speany.                                    | hite   |  |
| d within 72 h<br>giene.<br>ar than "nat<br>the Medica  | Completed      | 15. Deceden<br>(Specify only highe:<br>Elementary/Secondary (0-12)   | college (                              |  | (Give                  | dent's Usual Occ<br>kind of work dor<br>DO NOT use reti<br>alyst | upation<br>he during most of t<br>red) | working                                     | 1                          | secur                                      | ity Agenc  |  |
| ould be file<br>Mental Hy<br>arked othe<br>atic event,   | To Be (        | 17. Father's Name (First, Middle, George Beidl   |  |  |                        |  | Vale                                   | Name (First, Middl<br>ria Sho               | up                         |  |  |  |
| and 2 sho<br>salth and<br>1 27 is me<br>er trauma  |                | 19a. Informant's Name/Relations Ann Middleto   |  | ter  |                        |  |  | Rural Route Num                             |                            |  | ip Code)<br>d.20910  |  |
| Pages 1<br>nent of He<br>int: If iten<br>iry or oth  |                | 20a. Method of Disposition<br>1 ☑ Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (§  |  |  | lingt                  |  | .Cem 2/                                | O5/2008                                     | Arl                        |  | n,Va.  |  |
| permit. Departr Imports any Inju   |                | 21. Signature of Funeral Service   | kicensee'                              |  | 9                      | Himenpado<br>241 Co  | D°RTNAI<br>lumbia                      | DI FUNE<br>Blvd.Si                          | ERAL<br>Llver              | SERVIC<br>Sprin                            | CE, P.A.<br>ng, Md20910                                      |  |
| Physician  |                | 23a. Part1. Enter the disease, or<br>shock, or heart failure. List<br>Immediate Cause (Final<br>disease or condition   | only one cause on e                    | caused the death<br>each line.   |                        | ter the mode of d  | ying, such as care                     | diac or respiratory                         | arrest,                    |  | Approximate<br>Interval Between<br>Onset and Death           |  |
| /Medical<br>Examiner   | Į.             | resulting in death)  | Due to                                 | (or as a consequence of the cons | uence of):             |  |  |   |                            | 2  | years  |  |
| cate be executed hysician and the burial-transit   | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c |  |  |                        |  |  |   |                            |  |  |  |
| ath certific<br>attending p<br>for use as  | Physician/Mec  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  | 1 ☐ Live I                             | itcome pf pregna<br>birth 2   Feta<br>nant at time of d  | al death 3             | ⊒Ectopic pregna<br>□ Other (specify)                             | псу                                    |   | 23                         | 3d. Date of deli<br>Month                  | very<br>Day Year   |  |
| juires that the de<br>n signed by the a<br>ud be detached t  | þ              | Part II. Other significant conditi   | ons contributing to d                  | leath but not res  | ulting in the u        | nderlying cause  | given in Part I.                       |   |                            |  | the cause of death?  |  |
| : The law require<br>cate has been si,<br>page 2 should t  | Completed      |  |  |  |                        |  |  | — 24a. Wa<br>auf<br>pei<br>1∐ Yes           | opsy<br>formed?            | 24b. Were au<br>prior to death?<br>1 ☐ Yes | topsy findings available<br>completion of cause of<br>2 ☐ No |  |
| ysician: Th<br>is certificate<br>director, pag   | Be             | 25. Was case referred to medica examiner?  | Hospital:                              |  | ER/Outpatie            |  | )thor:                                 | Death (Check only                           | •                          |  |  |  |
| ding Phys<br>.r.<br>After this<br>funeral dir  | tion: To       | 1 ☐ Yes 2 ☒ No  27. Manner of Death  1 ☒ Natural 5 ☐ Pendir 2 ☐ Accident investi   | 28a. Date<br>(Mor                      |  | 28b. Time of Injury    | of 28c. In   | 4 🗆 Nursin                             | ng Home 5 X Re<br>28d. Describ              |                            |  | ony)   |  |
| To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director, f.   | Certification: | 2 Accident investing Suicide 6 Could 4 Homicide determine  | not be 28e. Place                      | e of injury - At he<br>ling, etc. (Specif  |                        | reet, factory, office  | ce                                     |   | (Street and<br>own, State) | Number or Ru                               | iral Route Number,   |  |
| the Hosp<br>in 24 hou<br>the Fune<br>ipletely fill   | Medical        | (Check only 2 Medical one)   | -                                      |  |                        | nvestigation, in m   | y opinion, death o                     |   | e, date and                | place, and due                             | to the cause(s)  |  |
| \  | Σ              | 29b. Signature and tiple of confifier  29c. License number  D38457  D38457  D38. 29d. Date signed (Month)  Jan. 28, 2  |  |  |                        |  |  |   |                            |  |  |  |
| 0  |                | 30. Name and address of person   |  |  |                        |  | Dr. Si                                 | lver Sp                                     |                            |  |  |  |
| Sta  |                | 31. Date filed (Month, Day, Year)  | 32.                                    | gistrar's Signa  | ature                  | Carle 1  | ,                                      |   |                            |  |  |  |

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 24, 2008 Ernestine MANDEL 9:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Nursing & Rehab Center Montgomery Silver Spring | Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth (Month, Day, Ports) | Hours | Min. | Ept. | 6, 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1□M 2**V**F 064-18-9625 96 Belgium Director Usual Residence of Decedent show 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f s 1 ☐ Yes 2 ☑ No Director Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10710 Lombardy Road 20901 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No white ģ Specify Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) French Teacher Education 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill f Health and Mental H tem 27 is marked oth 18. Mother's Name (First, Middle, Maiden Surname) Be Nathan Mandel Rachel Kantor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6642 Windsor Court, Columbia, MD 21044 Judith Stapler, Daughter : If item 27 or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages nent of h 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Mt. Lebanon Cemetery 101/25/08 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, MD 21. Signature of Funeral Service Licensee Tổrchinsky Hebrew Funeral Home <u>254 Carroll St., NW, Washington, DC</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRO VASCULAR **Physician** THER SCLEROTIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death Day 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð TVAL FAILURE 1 Yes 2 No 3 Probably 4 Donknown Completed To THRIVE AILURE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy perform certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ Mo Other: Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 s been signed by t should be detach this

filed within 72 hours after death with

Maryland 21215-0036

Baltimore,

Hospital or Attending Physician: filled in by the funeral director. within 24 hours a To the Funeral [

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29a. Certifier

Medical

State

Registrar

and manner stated.

29c. License number

D 28595

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAKHANI 2835 1 ASNEEM SmiTH

31. Date filed (Month, Day, Year) JAN 29 2008

SUITE 28S, BAUD MI) gistrar's Signature

Registrar

DHMH 17 Rev 1/2001

JAN 2 9

2008

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 24a,25 per dr., 2876,02/16/08dhb Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 22 2008 **Physician** 9:14 A<sup>M</sup> Anthony Clinton Miles January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis 963 Shadewater Way If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Jan 13, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number New York **Funeral** L 36 1<del>∏</del> M 2□F 72 122-28-1284 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10b. County 10a. State is merked other than "netural", or Items 23a or 28a-f show aumatic event, the Medicel Examiner must be notified at 1 X Yes 2 No Annapolis Maryland Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21401 963 Shadewater Way Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 Tyres 2 No If Yes, Give Year or Dates 1953 - 96 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🗓 No Black Baltimore, Maryland 21215-0036 Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Dickson Research College (1-4or 5+) Elementary/Secondary (0-12) Urban Institution Administrator 12th 4yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and 2 should be lealth and Mental Graynell Lawrence William Miles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Annapolis, Md. 21401 Department of Health a Important: If item 27 is eny Injury or other trat 963 Shadewater Way Barbara Miles(Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Crownsville, Md. 1-28-08 Maryland Veteran 4 ☐ Donation 5 ☐ Other (Specify) M Mame Research Acid Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 ese M00483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UState cancel o years **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death signed by the attending the detached for use 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown certificate hes been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 XNo 26. Place of Death Check onl one To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 3□ DOA 1 Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 27. Manner of De th 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 24 hours after death. Injury 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide To the Hospital within 24 hours at To the Funeral C 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bestgate Road #300, Amepolis, MD 21401 Canine

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Pagistrar's Signature

2008

|                |  |  | For State  | State of Maryland  |                               | artment of F<br>rtificate of .                |                          |                              | ental Hy                      | giene                  | 2008   | 1 1194  |
|----------------|--|--|--|--|-------------------------------|---|--------------------------|------------------------------|-------------------------------|------------------------|--|---|
| 7              |  | -  | Registrar  1. Decedent's Name (First, Middle, Last)  |  | Ce                            | runcate or                                    | Deair                    |                              | 2. Date of Dea                | Reg. No.               |  | 3. Time of Death                                    |
|                | Physici  |  | Exa deAlva Murray  | 7  |                               |   |                          |                              | Month<br>Januar               | Day                    | , 2008   | 12:00P M  |
|                | /Medio   |  | 4a. Facility Name (If not institution, give str  |  |                               | 4b. City, Town, o                             | r Location               |                              | Gariage                       |                        | County of Deat                                 |   |
|                |  |  | 10914 Clermont Aver  | iue  |                               | Garrett :                                     | Park                     |                              |                               | Мо                     | ntgomer  | У   |
|                | Funeral  |  | Social Security Number     6. Sex  | 7. Age (In yrs. In                                       |                               | If Under 1 Year<br>Months Days                | If Unde<br>Hours         | Min.                         | B. Date of Birt<br>(Month, Da | v. Year)               | Co   | thplace (State or Foreign ountry)                   |
| Ļ              | Director   |  | 258-22-4851 Usual Residence of Decedent  | 8  | 4 Yrs.                        |   |                          |                              | July 8                        | , 19                   | 23 Geo   | rgia  |
|                | rland<br>ow<br>at  |  | 10a. State 10b. County   | 10c. City  | , Town or Lo                  | ocation                                       |                          |                              |                               |                        |  | 10d. Inside City Limits                             |
|                | Many<br>Fish<br>fied   | 호  | MD Montgomery  | Garr   | ett Pa                        | ırk   |                          |                              |                               |                        |  | 1∭XYes 2 □ No                                       |
|                | h the<br>or 28a<br>o noti  | Director   | 10e. Street and Number   | 002.2  |                               | 10f. Zip Code                                 |                          |                              |                               | 10g. Citi              | zen of What Co                                 | ountry?   |
|                | th wit<br>23a c<br>ust be  | a D  | 10914 Clermont Aver  | iue  |                               | 20896   |                          |                              |                               | USA                    |  |   |
|                | tems   | Funeral  |  | 2. Was Decedent Ever in U.S<br>Armed Forces?             | 3. 13.                        | Was Decedent of H<br>If Yes, specify Cuba     | lispanic O<br>an, Mexica | rigin? (Spec<br>an, Puerto R | ify Yes or No<br>ican, etc.)  | -                      | <ol> <li>Race - Ame<br/>Black, Whit</li> </ol> |   |
| 36             | s afte   | by F   | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates:         |                               | 1 ☐ Yes 2 💢 No                                | Specify                  | y:                           |                               |                        | Specify: Whi                                   | **  |
| 21215-0036     | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or items 23a or 28a-f show<br>ant, the Medical Examiner must be notified at  | ed   | 15. Decedent's Educa   | tion I   | 16a. Dece                     | dent's Usual Occup                            | ation                    |                              |                               | 16b. Ki                | milia<br>nd of Business/                       |   |
| 215            | hin 7%   | ple  | (Specify only highest grade Elementary/Secondary (0-12)  | completed) College (1-4or 5+)                            | (Give<br>life.                | kind of work done<br>DO NOT use retired       | during mo<br>d)          | st of working                | , i                           |                        |  |   |
| 21             | filed withir<br>Hygiene.<br>other than<br>sent, the M  | Completed  | 12   |  | Secre                         | tary  |                          |                              |                               |                        |  | vernment  |
| pu             | be file<br>tal Hy<br>d oth<br>event  | Be   | 17. Father's Name (First, Middle, Last)  |  |                               |   |                          |                              | First, Middle,                |                        | ,  |   |
| Maryland       | S should be filed within and Mental Hygiene. is marked other than aumatic event, the Me  | 은  | Emory Barron Morris  19a. Informant's Name/Relationship (Type  |  | 405 14-111                    | ng Address (Street                            |                          |                              | llis B                        |                        |  | 7.04)   |
| Ma             | s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at |  | Patricia Wilbur/dau  | ,  | 1                             | Mackall                                       |                          |                              |                               | -                      |  | zip Code)   |
| ē,             | s 1 and 2<br>f Health<br>item 27 i   | 1 3  | 20a. Method of Disposition   | 20b. Pl  | ace of Dispo                  | osition (Name of<br>matory or other place     | 20)                      | Da                           | te                            | 20c. Lo                | cation - City or                               | Town, State   |
| 9              |  |  | 1 ☐ Burial 2 【Cremation 3 ☐ Rel<br>4 ☐ Donation 5 ☐ Other (Specify)  | HOVAL HOLL State   |                               | ce Cremato                                    |                          | 01/30                        | /08                           | Belt                   | sville,  | MD  |
| Baltimore,     | permit. Pages 1 ar<br>Department of Hes<br>Important: If item<br>any Injury or othe  |  | 21. Signature of Funeral Service bicenses  |  | -                             |   | -                        | ility                        | Sarvi                         | CA                     | P O Bo   | y 784   |
| <u> </u>       |  | MULES FROM MOIZE BEVERLY L. HECKROTTE, P.A. Clar |  |  |                               |   |                          |                              |                               | rksvill                | .e, MD 21029                                   |   |
| 8              |  |  | 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |                               |   |                          |                              |                               |                        |  | Approximate<br>Interval Between<br>Onset and Death  |
| 5              | Physician /Medical   | 9  | Immediate Cause (Final disease or condition resulting in death)  | Metastatic T   |                               | ional Ce                                      | 11 Ca                    | ancer                        | ,                             |                        |  | 2 months  |
|                | Examiner   |  |  | Due to (or as a consequ                                  | ence of):                     |   |                          |                              |                               |                        |  |   |
| 12             |  | er   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | Due to (or as a consequ                                  | ence of):                     |   |                          |                              |                               |                        |  |   |
|                | cuted<br>nd<br>ransit  | Examiner   | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |                               |   |                          |                              |                               |                        |  |   |
| Ő,             | e exe<br>ian ar<br>urial-t   | EX   | resulting in death) Last   | Due to (or as a consequ                                  | ence of):                     |   |                          |                              |                               |                        |  |   |
| 68760,         | death certificate be executed<br>e attending physician and<br>d for use as the burial-transit  | edical   | d.   | -  |                               |   |                          |                              |                               |                        |  |   |
|                | certifi<br>ding I<br>se as   |  | IF FEMALE: 230   | c. If yes, outcome pf pregnar                            | ncv                           |   |                          |                              |                               |                        | 23d. Date of de                                | livon   |
| Вох            | atten<br>atten<br>I for u  | Physician/M                                      | in the past 12 months?   | 1 ☐ Live birth 2 ☐ Fetal<br>4 ☐ Pregnant at time of de   | death 3                       | □Ectopic pregnancy<br>□ Other (specify)       | У                        |                              |                               | (                      | Month  | Day Year  |
| P.O.           | at the de<br>by the a  | hysi   | 1 ∐ Yes 2 🔀 No<br>9 □ Unknown  | 9□Unknown  |                               |   |                          |                              |                               |                        |  |   |
|                | The law requires that the ite has been signed by things 2 should be detache  | by P   | Part II. Other significant conditions control  | ibuting to death but not resu                            | Iting in the u                | nderlying cause giv                           | en in Part               | : 1.                         | 23e. Did to                   | obacco u               | ise contribute to                              | the cause of death?                                 |
| Vital Records, | w require<br>been siç<br>should t  |  |  |  |                               |   |                          |                              | 1 🗆 `                         | Yes 2                  | XNo 3□Pi                                       | robably 4 Unknown                                   |
| ပ္ပ            | e law r<br>has be  | Completed  |  |  |                               |   |                          |                              | 24a. Was                      |                        | prior to                                       | utopsy findings available<br>completion of cause of |
| H H            |  | Con  |  |  |                               |   |                          |                              | perfo<br>1□ Yes               | rmed?<br>2 <b>X</b> No | death?<br>1 ☐ Yes                              | 2 □ No  |
| Vita           | Physician:<br>this certificatal director,  | Be   | 25. Was case referred to medical examiner?   | spital:  |                               | oth 3D DOA Oth                                | or.                      | ,                            | Check only o                  |                        |  |   |
| 0              | Phys<br>r this<br>ral dir  | . To   | 1 Yes 2X No  | 28a. Date of Injury                                      | ER/Outpatier<br>28b. Time o   | IL OLI DOX                                    | 4 LI N                   |                              | e 5 XResid<br>3d. Describe I  |                        | 6 ☐Other (Spe                                  | ecify)  |
| OU             | th.<br>th.<br>: After<br>: funer   | tion   | 1 X Natural 5 ☐ Pending<br>2 ☐ Accident investigation  | (Month, Day Year)  | Injury                        | Wor   | k?<br>Yes 2 [            |                              | a. Dodonbo i                  | now injur              | y occurred                                     |   |
| Division       | Atter<br>r dea<br>ector<br>by the  | ifica  | 3 Suicide 6 Could not be determined  | 28e. Place of injury - At hor<br>building, etc. (Specify | me, farm, str                 | eet, factory, office                          |                          | 28                           |                               |                        |  | ural Route Number,                                  |
| ă              | talors after al Dir  | Certification:                                   | Tariomoldo   | building, etc. (Specify                                  | ,                             |   |                          |                              | City or Tov                   | vii, Siale             | )  |   |
|                | To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After t completely filled in by the funeral  |  | (Check only 2 Medical Examine  | cian: To the best of my knower: On the basis of examinat | vledge, deat<br>ion and/or in | h occurred at the til<br>vestigation, in my o | me, date a               | and place, ar                | nd due to the                 | cause(s)               | and manner as                                  | s stated.<br>e to the cause(s)                      |
|                | thin 2<br>the c  | Medical  | 29b. Signature and title of certifier  | and manner stated.                                       | 7                             | 29c. Licens                                   |                          |                              |                               |                        | te signed (Mont                                |   |
|                | T ¥ D S  |  | 3-1/2  | Manne  |                               |   |                          |                              |                               |                        |  |   |
| •              | 10 EG.   |  | 30. Name and address of person who com   | pleted cause of death (Item                              | 23a) (Tvne                    | DO98  | J <del>4</del>           | -                            |                               | Janu                   | ary 28,  | 2000  |
| -              | 1-06.  |  | Barry Rosenbaum, M.  | D. 3720 Farr   | agut A                        | ve. Kens:                                     | ingto                    | on, MD                       | 20895                         |                        |  |   |
|                | Sta  | te   | 21 Date filed (Month Day Veer)   | 32. Registrar's Signat                                   |                               |   |                          | ·                            |                               |                        |  |   |
|                | Registr  | ar   | JAN D U LU   | Neseur.  | Nº A                          |   |                          |                              |                               |                        |  |   |

Saltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760 To the Registrar DHMH 17 Rev 1/2001

(Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) it hilis Kinz-Home, Cois 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Libvie Keing-Moncilovic 1065 Concord \$# 500

Sensor 32. gistrar's Signature 31. Date filed (Month, Day, Year) JAN 2 8 2008 **ORIGINAL** 

|                     |  |                | For State Registrar   | State of                               | Maryland /                             |                           | artment o  |                  |             |                                  |                | 008                   | 04196  |  |  |
|---------------------|--|----------------|---|--|--|---------------------------|--|------------------|-------------|----------------------------------|----------------|-----------------------|--|--|--|
|                     | Physic   |                | Decedent's Name (First, Middle, Last  | ,                                      |  |                           |  | 2000             |             | 2. Date of Dea<br>Month          | Day            | Year                  | 3. Time of Death                               |  |  |
|                     | /Medi  |                | Lang Thi N  4a. Facility Name (If not institution, give                           | <u> </u>                               | her)                                   |                           | 4b. City, Tow  | n or Location    | of Doath    | January                          | 26             | 2008<br>inty of Death |  |  |  |
|                     | Exami  | ıer            | Holy Cross Hospi  |  | 501)                                   |                           | 1  |                  |             |                                  | 40.000         | Sec. 1                |  |  |  |
|                     | Funeral  | 0.00           | 5. Social Security Number 6. Se   |  | '. Age (In yrs. last                   | birthday)                 | If Under 1 Ye  | Silver S         | r 24 Hrs.   | 8. Date of Birth                 |                | Montgon<br>9 Birthr   |  |  |  |
| k                   | Director   |                | 579-17-0750   | □ M 2 🕱 F                              | 74                                     | Yrs.                      | Months Da  | ys Hours         | Min.        | (Month, Day<br>July 09           | r, Year)       | Cour                  | olace (State or Foreign<br>ntry)               |  |  |
|                     |  |                | Usual Residence of Decedent   |  |  |                           |  |                  |             | July 09                          | , 1733         |                       | Vietnam  |  |  |
|                     | ylany<br>now<br>at   |                | 10a. State 10b. County  |  | 10c. City, T                           | own or Lo                 | cation   |                  |             |                                  |                | 1                     | 10d. Inside City Limits                        |  |  |
|                     | Mar<br>a-f si  | 호              | Maryland Montgome:  | ry                                     |  |                           | Si   | lver Spr         | ing         |                                  |                |                       | 1 ☐ Yes 2 ☑ No                                 |  |  |
|                     | or 28  | Director       | 10e. Street and Number  |  |  |                           | 10f. Zip Cod   | е                |             |                                  | 10g. Citizen   | of What Cour          | ntry?  |  |  |
|                     | th with  | a              | 12004 Renick  | Lane                                   |  |                           |  | 20904            |             |                                  | V-             | ietnam                |  |  |  |
|                     | deal<br>ms   | Funeral        | 11. Marital Status  | 12. Was Deced<br>Armed Ford            | ent Ever in U.S.                       | 13.                       | Was Decedent   | of Hispanic O    | rigin? (Spe | ecify Yes or No-<br>Rican, etc.) |                | Race - Americ         |  |  |  |
| ထွ                  | after<br>or ite  |                | 1 ☐ Never Married 2 🗷 Married   | 1 Tes 2                                | ₹ No                                   |                           | ires, specily c<br>1 □ Yes 2 🗷 f   |                  |             | rican, etc.)                     |                | Black, White,         | etc.   |  |  |
| 8                   | ours<br>iral",<br>Exa  | d by           | 3 ☐ Widowed 4 ☐ Divorced  | Year or Date                           | es:                                    |                           | 10 163 201   | 40 Specify       | ·.          |                                  | Spe            | cify:                 | sian   |  |  |
| 5                   | 72 h<br>'natu<br>dical   | Completed      | 15. Decedent's Edi<br>(Specify only highest grad                                  | ucation<br>de completed)               | 1                                      | 6a. Dece                  | dent's Usual Oc<br>kind of work do   | cupation         | st of worki | na l                             | 16b. Kind o    | f Business/Inc        | dustry   |  |  |
| 7                   | ithin<br>ne.<br>han '  | ם              | Elementary/Secondary (0-12)   | College (1-4                           | for 5+)                                | life. I                   | DO NOT use rei   | tired)           |             |                                  |                |                       |  |  |  |
| 7                   | e filed w<br>al Hygie<br>other tl<br>vent, th  | ပ္ပ            | 3   |  |  |                           | Home   | emaker           |             |                                  | Domestic       |                       |  |  |  |
| Ē                   | be fill H d oth  | Be             | 17. Father's Name (First, Middle, Last)   | Unkno                                  | own                                    |                           |  | 18. Moth         | ner's Name  | (First, Middle,                  | Maiden Surr    | name) [               | Jnknown  |  |  |
| $\frac{8}{5}$       | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.<br>Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at   | ၉              |   | ,,                                     |  |                           |  |                  |             |                                  |                |                       |  |  |  |
| Maryland 21215-0036 | 2 sh<br>and<br>Is m  | 1              | 19a. Informant's Name/Relationship (T   | ype. Print)                            | 1                                      | 19b. Mailir               | ig Address (Stre   | et and Numb      | ber or Rura | al Route Numbe                   | r, City or Tov | vn, State, Zip        | Code)  |  |  |
|                     | 1 and 2<br>Health<br>em 27   |                | Tony Van Pham - Son   | <u>n</u>                               | Tool Di-                               |                           |  |                  |             | Spring, 1                        |                |                       |  |  |  |
| altimore,           | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar<br>Department of Health and Mental Hygiene.<br>Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show<br>any Injury or other traumatic event, the Medical Examiner must be notified at<br>once. |                | 20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ I                         | Removal from St                        | l come                                 | e of Dispo<br>etery, crer | sition (Name of<br>natory or other   | olace)           | D           | Pate                             | 20c. Locatio   | n - City or To        | own, State                                     |  |  |
| <u>E</u>            | . Pa<br>tmen<br>tant:<br>jury  |                | 4 □ Donation 5 □ Other (Specify   | )                                      |  |                           | aven Ceme  | -                | -           | L/2008                           | Silver         | Spring,               | Maryland                                       |  |  |
| Bai                 | permit. Departr Importa any Inje   |                | 21. Signature of Funeral Service Licens   | ee                                     | 4.                                     |                           | . Name and Ad  |                  | -           | lome, Inc.                       |                |                       |  |  |  |
|                     | 0 □ = # 0  |                | Noney A.V.  | acen                                   | Ne                                     |                           | 1800 New   | Hampshi          | re Ave      | enue, Silv                       | ver Spri       | ing, Mar              | yland 20904                                    |  |  |
| 4                   |  |                | 23a. Part1. Enter the disease, or comp<br>shock, or heart fattore. List only of   | lications that cau<br>one cause on eac | used the death. Do<br>th line.         | o not ent                 | er the mode of   | dying, such as   | s cardiac o | r respiratory arr                | rest,          |                       | Approximate<br>Interval Between                |  |  |
| g.                  | Physician  |                | Immediate Cause (Final disease or condition                                       | a Myoca                                | rdial Infa                             | arctic                    | n  |                  |             |                                  |                | 1                     | Onset and Death                                |  |  |
|                     | /Medical<br>Examiner   |                | resulting in death)   |  | r as a consequenc                      |                           |  |                  |             |                                  |                |                       |  |  |  |
| B                   | Examine  |                | Sequentially list conditions.   |  | nary Artery                            |                           | ase  |                  |             |                                  |                |                       |  |  |  |
|                     | p #  | ine            | Sequentially list conditions, if any leading to immediate cause. Enter Underlying | Due to (or                             | as a consequenc                        | ce of:                    |  |                  |             |                                  |                |                       |  |  |  |
|                     | ecute<br>and<br>trans  | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last           |  | tension                                |                           |  |                  |             |                                  |                |                       |  |  |  |
| Ö,                  | e exc<br>cian a<br>urial-  |                | resulting in death) East  | as a consequenc                        | ce of):                                |                           |  |                  |             |                                  |                |                       |  |  |  |
| 8760,               | icate be executed<br>physician and<br>s the burial-transit   | dical          |   | d. Diabe                               | tes Mellit                             | tus                       |  |                  |             |                                  |                |                       |  |  |  |
| 9                   |  | Mec            | IF FEMALE:  |  |  | _                         |  |                  |             |                                  |                |                       |  |  |  |
| ROX                 | death certifi<br>e attending I<br>id for use as  | an/            | 23b. Was decedent pregnant in the past 12 months?                                 |  | me pf pregnancy<br>th 2  Fetal dea     | ath 3                     | lEctopic pregna  | ncy              |             |                                  | 1              | Date of delive        | •  |  |  |
|                     | 0 0  | Sic            | 1 ☐ Yes 2 🔼 No<br>9 ☐ Unknown   | 4□Pregnar<br>9□Unknow                  | nt at time of death<br>n               | 5                         | Other (specify)  | )                |             | -                                |                | Month                 | Day Year                                       |  |  |
| J.                  | requires that the<br>een signed by th<br>nould be detache  | Physician/Me   |   |  |  |                           |  |                  |             | T                                |                |                       |  |  |  |
| ecords,             | res th   | þ              | Part II. Other significant conditions co  | ntributing to deat                     | in but not resulting                   | g in the ur               | iderlying cause  | given in Part    | I.          |                                  |                |                       | ne cause of death?                             |  |  |
| 5                   | w requires<br>been signe<br>should be  | Completed      |   |  |  |                           |  |                  |             | 1 U Y                            | es 2∐ No       | 3 Prob                | ably 4 🔣 Unknown                               |  |  |
| မ                   | S S S  | ple            |   |  |  |                           |  |                  |             | 24a. Was a                       | in 24          | b. Were auto          | psy findings available<br>mpletion of cause of |  |  |
| ř                   | Th<br>afe<br>pag   | 20             |   |  |  |                           |  |                  |             | perfori                          | med?<br>2 🕱 No | death?                | 2□ No  |  |  |
| VIta                | Physician: The lithis certificate ha   | Be (           | 25. Was case referred to medical examiner?  |  |  |                           |  | 26. Place        | e of Death  | (Check only on                   |                |                       |  |  |  |
| <u>_</u>            | Physic<br>this o   | 2              | 1 ☐ Yes 2 🕱 No  | Hospital:<br>1 ☐ Inp                   | atient 2 ER/0                          | Outpatien                 | 3 🗷 DOA  | Other: 4 🗆 Ni    | ursing Hon  | ne 5□Reside                      | ence 6 □C      | Other (Specify        | y)   |  |  |
|                     |  |                | 27. Manner of Death  1 X Natural 5 ☐ Pending                                      | 28a. Date of (Month,                   | Injury 28t<br>Day Year)                | o. Time of<br>Injury      | 28c. lr  | jury at<br>vork? | 2           | 8d. Describe ho                  | ow injury occ  | urred                 |  |  |  |
| SION                | Attending r death. ector: After by the fune  | Sati           | 2 ☐ Accident Investigation  |  |  |                           |  | ☐Yes 2☐          | No          |                                  |                |                       |  |  |  |
| Ž                   | ter de lirect  | Certification: | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined                           | 28e. Place of<br>building              | injury - At home,<br>, etc. (Specify)  | farm, stre                | et, factory, offic   | е                | 2           | 8f. Location (St<br>City or Town |                | mber or Rura          | l Route Number,                                |  |  |
|                     | spital or Attend tours after death. neral Director: /  |                |   |  |  |                           |  |                  |             |                                  |                |                       |  |  |  |
|                     | 6 # II 은   | edical         | 29a. Certifier 1  Certifying Phy (Check only one) 2  Medical Exami                | sician: To the be<br>iner: On the basi | est of my knowled<br>is of examination | lge, death<br>and/or inv  | occurred at the restigation, in m  | e time, date a   | nd place, a | and due to the c                 | ause(s) and    | manner as st          | tated.   |  |  |
|                     | To the Hos within 24 hd To the Fun completely  | Medi           | 5.1.07  | and manner                             | r stated.                              |                           |  |                  |             |                                  |                |                       |  |  |  |
|                     | S with   | -              | 29b. Signature and title of certifier   | 1.6                                    | MP                                     |                           | 29c. Lice  | nsė number       |             | 2                                | 9d. Date sig   | ned (Month, I         | Day, Year)                                     |  |  |
|                     | V  |                |   | 110                                    | - , ,                                  |                           |  | D54486           |             |                                  | January        | 29, 20                | 08   |  |  |
|                     |  |                | 30. Name and address of person who co   |  |  |                           |  |                  |             |                                  |                |                       |  |  |  |
| سنر                 | *  |                | Huyanh Ton, M.D.,   |  |  | Avenu                     | e, Suite   | #310, T          | akoma       | Park, Mar                        | ryland 2       | 20910                 |  |  |  |
|                     | Sta<br>Registra  |                | JAN 3 0 200   | 4                                      | istrar's Signature                     | L                         | all s  |                  |             |                                  |                |                       |  |  |  |
|                     | ~ ~  |                | O O LOC   |  | THE ST                                 | 100                       | TO STATE OF THE PARTY OF THE PA |                  |             |                                  |                |                       |  |  |  |

DHMH 17 Rev 1/2001

|                            |  |                           | For<br>State<br>Registrar  | 5  | State o                                 | of Marylar                        | nd / Depa       | artmei<br>rtifica     | nt of H<br><i>te of L</i>               | ealth a<br>Death       | ınd Me       |                             | giene<br>Reg. No. | 200                  | 8 01                           | +19               |  |
|----------------------------|--|---------------------------|--|--|---|-----------------------------------|-----------------|-----------------------|---|------------------------|--------------|-----------------------------|-------------------|----------------------|--------------------------------|-------------------|--|
| 池                          |  |                           | Decedent's Name (First, Mid  | dle, Last)   |   |                                   |                 |                       |   | Journ                  | 2            | . Date of Dea               |                   |                      | 3. Time                        | of Death          |  |
| П                          | Physici  |                           | Hao Thanh Nh   | am   |   |                                   |                 |                       |   |                        |              | Month                       | Day               | Year                 | r                              | M                 |  |
|                            | /Medic   |                           | 4a. Facility Name (If not instituti  |  | eet and nu                              | ımber)                            |                 | 4b. City              | . Town, or                              | Location o             |              | January                     |                   | 2008<br>County of De |                                | toa               |  |
|                            | Examir   | ier .                     |  |  |   |                                   |                 |                       |   |                        |              |                             |                   |                      |                                |                   |  |
|                            | Funeral  |                           | Washington Ad 5. Social Security Number  | venti<br>6. Sex  | St HC                                   | 7. Age (In yrs.                   | last birthday)  |                       | akoma<br>er 1 Year                      | Park                   |              | . Date of Birtl             | h                 | Montg<br>9.8         | omery<br>irthplace (State      | e or Foreian      |  |
|                            | Funeral<br>Director  |                           | ,  |  | 1 2 <b>∏</b> F                          |                                   | Yrs.            | Months                | Days                                    | Hours                  | Min.         | (Month, Day                 | , Year)           |                      | Country)                       |                   |  |
| 0                          | repair Als Borns   |                           | 577-11-7812 Usual Residence of Decedent  |  |   | 71                                |                 |                       |   |                        | [ A          | April :                     | 21,               | 1936 C               | nina                           |                   |  |
|                            | ylanc<br>ow<br>at  |                           | 10a. State 10b. Coun   | ty   |   | 10c. Ci                           | ty, Town or Lo  | cation                |   |                        |              |                             |                   |                      | 10d. Inside                    | City Limits       |  |
|                            | Mar-f sh   | ţō                        | Manus I am d   | Danis  | ~~ C~                                   | orge's                            |                 |                       | D +                                     |                        |              |                             |                   |                      | 1 □ Ye                         | es 2 No           |  |
|                            | h the Marylan<br>r 28a-f show<br>r notified at   | Director                  | Maryland  <br>10e. Street and Number   | _ PI III   | ce_Ge                                   | orge's                            |                 |                       | Brent<br>ip Code                        | _DOOW.                 |              |                             | 10g. Citiz        | en of What 0         | Country?                       |                   |  |
|                            | th with<br>23a or<br>1st be  | 0                         | 4142 Bunker  | H411   | beag                                    | #51Q                              |                 |                       | 2072                                    | 2                      |              |                             | 17 i o i          | nam                  |                                |                   |  |
|                            | ter death with the Maryland<br>Items 23a or 28a-f show<br>Iner must be notified at   | Funeral                   | 11. Marital Status   |  | . Was Dec                               | edent Ever in U                   | l.S. 13.        | Was Dec               |   |                        | gin? (Speci  | fy Yes or No-<br>can, etc.) |                   | 4. Race - An         | nerican Indian,                |                   |  |
| 36                         | after<br>or Ite  | by Fur                    | 1 □ Never Married 2 □ Ma   |  | Armed For 1 Yes If Yes, Given Year or D | 2 □ <b>X</b> No<br>ive            |                 | lf Yes, sp<br>1 □ Yes |   | n, Mexican<br>Specify: | , Puerto Ri  | can, etc.)                  |                   | Black, Wh            |                                |                   |  |
| 21215-0036                 | 72 hc<br>natul<br>lical  | Completed                 | 15. Decede<br>(Specify only high   | ent's Educa<br>nest grade d  | tion                                    |                                   | 16a. Dece       | kind of w             | ork done d                              | durina most            | of working   |                             | 16b. Kir          | d of Busines         | s/Industry                     |                   |  |
| 21                         | within ene. than "   | 횬                         | Elementary/Secondary (0-12)  |  |   | 1-4or 5+)                         | `life.          | DO NOT                | use retired                             | )                      |              |                             |                   |                      |                                |                   |  |
| 2                          | filed w<br>Hygier<br>ther th   | ပွဲ                       | 0  |  |   |                                   | Fa              | ctor                  | y Wor                                   |                        |              |                             |                   | od Ind               | ustry_                         |                   |  |
| nd                         | be filed<br>tal Hygi<br>d other<br>event, tl   | Be                        | 17. Father's Name (First, Middle   | e, Last)   |   |                                   |                 |                       |   | 18. Mother             | r's Name (   | First, Middle,              | Maiden 3          | Surname)             |                                |                   |  |
| <u>×</u>                   | Men<br>arke  | မ                         | Unknown  |  |   |                                   |                 |                       |   | Un                     | knowr        | 1                           |                   |                      |                                |                   |  |
| Maryland                   | 2 should be<br>n and Menta<br>is marked<br>raumatic ev   |                           | 19a. Informant's Name/Relation   |  | . Print)                                |                                   | 19b. Mailir     | ng Addres             | ss (Street a                            | and Numbe              | r or Rural i | Route Numbe                 | er, City or       | Town, State          | , Zip Code)                    |                   |  |
|                            | and<br>salth<br>n 27<br>er tr  |                           | Con Manh Nham  | /Son   |   |                                   | 69 R            | idge                  | Road                                    | l, Gre                 | enbel        | Lt, MD                      | 207               | 70                   |                                |                   |  |
| altimore,                  | permit. Pages 1 a Department of Hes Important: If item any injury or othe  |                           |  |  | noval from                              | State                             | cemetery, crei  | matory or             | other plac                              |                        | Jan.         | 30,                         |                   |                      |                                |                   |  |
| =                          | nit. Fartme  |                           |  | Signature of Funeral Service Licensee   State   Signature of Funeral Service Licensee   Signature Office Licensee   Signature Office Licensee   Signature Office Licensee   Signature Office Licensee   Sign |   |                                   |                 |                       |   |                        |              |                             |                   |                      |                                |                   |  |
| B                          | permi<br>Depa<br>Impo<br>any ir  | 6 J                       | Con Manh Nham/Son  69 Ridge Road, Greenbelt, MD 20770  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Appropriate Tables and Part Conservations of Pacific Specific Conservations of Pacific Conservat |  |   |                                   |                 |                       |   |                        |              |                             |                   |                      |                                |                   |  |
|                            |  |                           |  |  |   |                                   |                 |                       |   |                        |              |                             |                   |                      |                                |                   |  |
|                            |  | e 10                      | shock, or heart failure. Li<br>Immediate Cause (Final  | st only one  | cause on                                | each line.                        |                 |                       | do or dym.                              | g, 5401. 40            | 0414140      | icopilatory ai              | 1001,             |                      | Interval B<br>Onset an         | etween<br>d Death |  |
|                            | Physician<br>/Medical  |                           | disease or condition resulting in death)  Due to (or as a consequence of):   |  |   |                                   |                 |                       |   |                        |              |                             |                   |                      |                                |                   |  |
|                            | Examiner   |                           | ,  |  | Due to                                  |                                   |                 |                       |   |                        |              |                             |                   |                      |                                |                   |  |
| 2                          |  | _                         | Sequentially list conditions,  | b  | D t.                                    | RENA                              |                 | 1164                  | RE                                      |                        |              |                             |                   |                      |                                |                   |  |
|                            | sit sd   | ine                       | Sequentially list conditions,<br>cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events  | 2  |   | or as a conse                     |                 |                       |   |                        |              |                             |                   |                      | 1                              |                   |  |
|                            | cate be executed<br>physician and<br>the burial-transit  | Examiner                  | that initiated events<br>resulting in death) Last  | с  | Dun An                                  | (or as a consec                   | NARY            | EM                    | 1BOL                                    | us                     |              |                             |                   |                      | -                              |                   |  |
| 30,                        | sian a   | Ê                         | 70001119   |  | Due to                                  | 1 /                               | ·               |                       |   |                        |              |                             |                   |                      |                                |                   |  |
| 8760,                      | ate t<br>hysic<br>the b  | dical                     |  | d  |   | 17 7161                           | TENSI           | 6 N                   |   |                        |              |                             |                   |                      |                                |                   |  |
| 9                          | ertific<br>ing p   | Mec                       | IF FEMALE:   |  |   |                                   |                 |                       |   |                        |              |                             |                   |                      |                                |                   |  |
| Вох                        | requires that the death certific<br>een signed by the attending p<br>lould be detached for use as  | Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months?  | 230  |   | itcome pf pregn<br>birth 2 ☐ Feta |                 | Ectopic :             | pregnancy                               |                        |              |                             | 2                 | 3d. Date of d Month  | elivery<br>Day                 | Year              |  |
| -                          | ed for   | sici                      | 1 ☐ Yes 2 🛣 No   |  | 4□Preg<br>9□Unkr                        | nant at time of o                 | death 5         | Other (s              | specify)                                |                        |              |                             |                   | MOHEL                | Day                            | 1 ear             |  |
| P.0                        | at the   | hy                        | 9 ☐ Unknown  |  |   |                                   |                 |                       |   |                        |              |                             |                   |                      |                                |                   |  |
|                            | w requires that the d<br>been signed by the<br>should be detached  | ò                         | Part II. Other significant condi   |  | -                                       |                                   |                 |                       |   | en in Part I.          |              |                             |                   |                      | to the cause o                 |                   |  |
| 5                          | en si  | pa                        | DIAB   | ETES   | 1                                       | IELLITI                           | x S             |                       |   |                        |              | 1 T                         | 'es 2□            | No 3                 | Probably 4 [                   | ∐Unknown          |  |
| Š                          | > 0 10   | olet                      | CORO   | NAR  | Y A                                     | IELLITI<br>IRTER                  | y Di            | SEA.                  | 5 E                                     |                        |              | 24a. Was a                  |                   | 24b. Were            | autopsy finding                | available         |  |
| æ                          | The law<br>cate has<br>page 2 s  | E I                       |  |  | *                                       |                                   |                 |                       |   |                        |              | autop                       | rmed?             | death'               | ocompletion of<br>?<br>es 2⊟No | r cause or        |  |
| ta                         | ician: Th<br>certificate<br>ector, pag   | Ö                         | 25. Was case referred to medic   | al   |   |                                   |                 |                       |   | 26 Place               | of Death /   | 1□ Yes<br>Check only o      | 2 No              | 1 1 1 1 6            | es ZUNO                        |                   |  |
| 5                          | Physician;<br>r this certific<br>ral director,   | To Be                     | examiner?<br>1 ☐ Yes 2 ☑ No  |  | spital:                                 | dnpatient 2□                      | I FR/Outnatier  | t 3 🗆 🗅               | OA Othe                                 |                        |              | e 5 ☐ Resid                 |                   | Dother (Co           |                                |                   |  |
| 0                          | Phy<br>er this   |                           | 27. Manner of Death  |  | 28a. Date                               | of Injury                         | 28b. Time o     |                       | 28c. Injury<br>Work                     | 7 🗆 140                |              | d. Describe h               |                   |                      | ecity)                         |                   |  |
| on                         | ding<br>h.<br>Afte   | ţi                        | 1 Natural 5 ☐ Pend<br>2 ☐ Accident inves   | ling<br>tigation   | (Mor                                    | nth, Day Year)                    | Injury          | м                     |   | <br Yes 2∐1            | No           |                             |                   |                      |                                |                   |  |
| Division or Vital Records, | Attending<br>r death.<br>ector: After<br>by the funer  | Certification:            | 3 ☐ Suicide 6 ☐ Coul   | d not be   | 28e. Place                              | e of injury - At h                | ome, farm, str  | eet, facto            | rv. office                              |                        | 28           | f. Location (S              | treet and         | l Number or          | Rural Route Ni                 | umber             |  |
| Ö                          | or A<br>after<br>Dire  | i i                       | 4 ☐ Homicide detel   | mined  | build                                   | ling, etc. (Speci                 | fy)             |                       | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                        |              | City or Ton                 | n, State)         |                      |                                | 2772011           |  |
| _                          | polital<br>ours<br>eral<br>filled  | Ö                         | 29a. Certifier 1 Certify   | ing Physic   | lan: To the                             | e best of my kno                  | owledge, deat   | h occurre             | d at the tim                            | ne date an             | d place, an  | d due to the                | ratico(c)         | and manner           | as stated                      |                   |  |
|                            | To the Hospital or Attending Physician; within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director, | Medical                   | (Check only 2 Medic  | al Examine   | r: On the b                             | pasis of examination of states.   | ation and/or in | vestigatio            | on, in my o                             | pinion, dea            | th occurred  | at the time,                | date and          | place, and d         | ue to the cause                | e(s)              |  |
|                            | To the To the To the Sormp   | M                         | 29b. Signature and title of certif   | ier , ,  | _                                       |                                   |                 | 29                    | 9c. License                             | e number               |              |                             | 29d. Date         | signed (Mo           | nth, Day, Year,                | )                 |  |
|                            | , [  |                           | •  | 17   |   | MD                                |                 |                       | 054                                     | 1486                   |              |                             | JAN               | WARY                 | 29,20                          | 808               |  |
|                            | 4  | -                         | 30. Name and address of person   | n who com  | nleted cau                              | se of death /Itor                 | n 23a) (Type    | Print\                |   |                        |              |                             |                   |                      | -/                             | -                 |  |
|                            |  |                           | Huyanh T. Ton  | , MD   | 750                                     | 5 New H                           | ampshi          |                       | venue                                   | , #31                  | .О, Та       | ikoma I                     | Park,             | MD 2                 | 0912                           |                   |  |
|                            | Sta<br>Registr   | -                         | 31. Date filed (Month, Day, Yea JAN 2  |  |   | egistrar's Signa                  | ature           | BOLL                  | 9                                       |                        |              |                             |                   |                      |                                |                   |  |

ending physician and use as the burial-tran Division or Vital Records, P.O. Box 68760, the attending physician

death with the Maryland

Baltimore, Maryland 21215-0036

|  | u.  |  |  |  |
|--|---|--|--|--|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  | 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown         | 3 □Ectopic pregnancy<br>5 □ Other (specify)  |  | 23d. Date of delivery<br>Month Day Y                             |
| Part II. Other significant conditions the plant of the pl | ons contributing to death but not resulting in th   | e underlying cause given in Part I.  | 23e. Did tobacc                                    | o use contribute to the cause of de<br>2 No 3 Probably 4         |
| dement   | 7'4   | ,  | 24a. Was an autopsy performed′                     |  |
| 25. Was case referred to medica  | d .   | 26. Place of Dea   | th (Check only one)                                |  |
| examiner?<br>1 ☐ Yes 2 No  | Hospital: 1 Inpatient 2 ☐ ER/Outpa  | tient 3 DOA Other: 4 Nursing H   | ome 5 Residence                                    | 6 ☐Other (Specify)   |
| 27. Manner of Death  1 Natural 5 Pendir 2 Accident investi   |   |  | 28d. Describe how in                               | njury occurred   |
| 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide determ   |   | street, factory, office  | 28f. Location (Street<br>City or Town, St.         | and Number or Rural Route Numbate)                               |
| 29a. Certifier 1 Certifyii (Check only one) 2 Medical  | ng Physician: To the best of my knowledge, d<br>Examiner: On the basis of examination and/o<br>and manner stated. | eath occurred at the time, date and place<br>or investigation, in my opinion, death occu | e, and due to the cause<br>irred at the time, date | e(s) and manner as stated.<br>and place, and due to the cause(s) |
| 20h Signature and title of certifie  | er e  | 29c. License number  | 29d. I   | Date signed (Month, Day, Year)                                   |

10

To the I

address of person who completed cause of death (Item 23a) (Type, Print) ole Veteri, MD 9901 Medical Center Dr., Rockville, MD 20850 Nicole Veteri, MD

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier



**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at

filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0036

death with the Maryland

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

State

851-

31. Date filed (Month, Day, Year)

| disease or condition resulting in death)   | a. Acute Ny O Cavolio 121-onc From Due to (or as a consequence of):  |                    |
|--|--|--------------------|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Ptherosclerotic Candio Vascular diferse  Due to (or as a consequence of):  C  |                    |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome pf pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)  9 Unknown   | Year               |
| Part II. Other significant conditions co   | ontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of  | death?             |
| End Stage  | Renal Failure 1 Yes 2 No 3 Probably 4 F  | Unknown            |
| AspiroHon<br>Small box   | performed?   death?  | available cause of |
| 25. Was case referred to medical   | 26. Place of Death (Check only one)  |                    |
| examiner?<br>1 Tes 2 No  | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  |                    |
| 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation   | 28a. Date of Injury (Month, Day Year)  28b. Time of Injury  M 28c. Injury at Work?  1  Yes 2 No  |                    |
| 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number of Rural Ro | mber,              |
|  | ysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Inner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause( and manner stated.  | (s)                |
| 29b. Signature and title of certifier  | 29c. License number 29d. Date signed (Month, Day, Year)  |                    |
| Leyo   | n.c. Smara. D 50653 1-25-2008  | j<br>h             |

Hospital or Attending Physician:

GYAN -C

SURANA

Deale

Church ton

Registra/s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

eale

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04200 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:33 a<sub>M</sub> Joseph Poznerzon January 2008 28 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 125M 2□ F Director Yrs. 577-46-8728 84 January 1, 1924 Poland Usual Residence of Decedent d 2 should be filed within 72 hours efter deeth with the Maryland than d Mental Hygiene.

71 is marked other than "natural", or itema 23a or 28a-f ahow traumatic event, the Medical Examinar maturalical and the model of the control of the model of the control of the model. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itema 23a or 28a-f ahov the Medical Examinar must be notified at Director 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13900 Alderton Road 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Painter Contractor Painting permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Itam 27 is marked other
any injury or other traumation... 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ Mordechai Poznerzon Baila Tondowska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Tallman - Daughter 13710 Alderton Road, Silver Spring, Maryland 20906 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 01/30/2008 Olney, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 manda 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Atherosclerotic Heart Disease Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to intra diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Das to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, End Stage Renal Disease 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? hes Hypertension performed? Type 2 Diabetes 2□ No 1 Yes 2**K** No Director: After this certific I in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DDA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral C 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

31. Date filed (Month, Day, Year) JAN 3 0

30. Name and addres of person for completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certified



2

01/28/08 10:33AM

POZNERZON, JOSEPH

29c. License number

D47188

29d. Date signed (Month, Day, Year)

January 29, 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death <sup>Day</sup> **28 Physician JANUARY** 2008 GARRY A. PEPPER 10:43AM<sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 13517 MAIN ST. QUEEN ANNE TALBOT 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1**X** M 2□ F Director 28,1963 220-90-4932 44 SEPT. MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. It! If item 27 is marked other than "natural" or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified 1 Yes 2 No Director MD TALBOT **QUEEN ANNE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral 13517 MAIN ST. 21657 or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: ģ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) the HORSE TRAINER HORSE RACING 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ GEORGE F. PEPPER, JR. MARGARET FISHER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13517 MAIN ST., QUEEN ANNE, MD 21657 : If item 2 or other MARGARET PEPPER/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ■ Burial 2 Cremation 3 Removal from State Department o Important: If any injury or once. FAIRVIEW CHURCH CEMETERY 2/1/2008 CORDOVA, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) the to (or as a consequence of): Physician Cardiovoscolor /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy performed? 2 KNo 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) 1 ¥ Yes 2 □ No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only onel 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pt RO. OXFURD, MD 21654 4410 Backelan Kop Rous Co laude 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JAN 3 0 2008 Registrar

|             |  |                | 1 - For<br>Registrar  | State of M                       | aryland / Dep<br><i>Ce</i>                        | artment of Herificate of D  |  | -                                   | ene 0 0 8                               | 04202                               |  |  |
|-------------|--|----------------|---|----------------------------------|---|---|--|-------------------------------------|---|-------------------------------------|--|--|
|             | Physici<br>/Medic  |                | 1. Decedent's Name (First, Middle, Las  | V ROI                            | BERT  | PEARL   | MAN  | 2. Date of Death<br>Month<br>ANU AR | Day 26, 200                             | 3 12407 M                           |  |  |
|             | Examir   | er             | 4a. Facility Name (If not institution, give   |                                  |   | 4b. City, Town, or  |  |                                     | 4c. County of De                        |                                     |  |  |
|             |  |                | Hebrew Home of Great  5. Social Security Number 6. |                                  | on<br>ge (In yrs. last birthday                   | Ro  | ockville If Under 24 Hrs.                    | 8. Date of Birth                    | Montg                                   | omery<br>inhplace (State or Foreign |  |  |
| ř           | Funeral Director   |                |   | <b>X</b> M 2□F                   | 84 Yrs.   | Months Days   | Hours Min.                                   | (Month, Day, )                      | rear) (                                 | New York                            |  |  |
|             |  |                | Usual Residence of Decedent   |                                  | 04  |   |  | mich 5,                             | 1723                                    | New TOTK                            |  |  |
|             | yland  |                | 10a. State 10b. County  |                                  | 10c. City, Town or L                              | ocation   |  |                                     |   | 10d. Inside City Limits             |  |  |
|             | Mar  | to             | Maryland Montgome   | ry                               |   | Ro  | ckville                                      |                                     |   | 1 ☐ Yes 2 🛣 No                      |  |  |
|             | or 28  | Director       | 10e. Street and Number  |                                  |   | 10f. Zip Code   |  | 10                                  | g. Citizen of What (                    | Country?                            |  |  |
|             | th wi  |                | 6105 Montrose   | Road                             |   | 2   | 20852  |                                     | ប.ន                                     | .A.                                 |  |  |
|             | r dea  | Funeral        | 11. Marital Status  | 12. Was Decedent<br>Armed Forces | Ever in U.S. 13.                                  | Was Decedent of His<br>If Yes, specify Cuban                          | spanic Origin? (Spe<br>n, Mexican, Puerto I  | cify Yes or No-<br>Rican, etc.)     | 14. Race - An<br>Black, Wh              |                                     |  |  |
| 36          | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or liems 23s or 28s-1 show<br>ont, the Medical Exam wer must be motified at  | by Fu          | 1 Never Married 2 Married   | 1 x Yes 2 ☐                      | WWII  | 1 ☐ Yes 2 ₺ No  | Specify:                                     |                                     | Specify:                                |                                     |  |  |
| 21215-0036  | hour<br>tural  | d b            | 3 Widowed 4 Divorced  | Year or Dates:                   | -20   | danie Harri Oanna   | *:   | 14                                  | 6b. Kind of Busines                     | White                               |  |  |
| <u>.</u>    | n 72   | lete           | 15. Decedent's Ed<br>(Specify only highest gra  | de completed)                    | (Give   | ident's Usual Occupa<br>I kind of work done di<br>DO NOT use retired) | uring most of workii                         |                                     | DD. KING OF BUSINES                     | Smoustry                            |  |  |
| 72          | with<br>lene.<br>then  | Completed      | Elementary/Secondary (0-12)  12   | College (1-4or                   | 5+)   | Manager   |  |                                     | Ret                                     | ail                                 |  |  |
|             | Hyg<br>other   | Be C           | 17. Father's Name (First, Middle, Last)   |                                  |   |   | 18. Mother's Name                            | (First, Middle, Ma                  | aiden Sumame)                           |                                     |  |  |
| a           | Ald be<br>fenta<br>fenta<br>rked<br>ric av   | To B           | Morris Pearl  | man                              |   |   | Mini   | nie Weisbei                         | in                                      |                                     |  |  |
| Maryland    | 12 should be filed within h and Mental Hygiene. 7 is marked other than "raumatic avent, the Men  |                | 19a. Informant's Name/Relationship (7   | ype, Print)                      | 19b. Maif   | ng Address (Street a  | nd Number or Rura                            | l Route Number,                     | City or Town, State,                    | Zip Code)                           |  |  |
|             | and 2<br>Balth a<br>n 27 is  |                | Dale Pearlman - Da  | ughter                           | 1824  | 9 Rolling Me  | eadow Way, (                                 | Olney, Mary                         | yland 20832                             |                                     |  |  |
| altimore,   | of He<br>of He<br>fitem  |                | 20a. Method of Disposition  1 ☑ Burial ☑ Cremation 3 ☐  | Removal from State               | 20b. Place of Disponentery, cre                   | osition (Name of<br>matory or other place                             |  | ate 20                              | Oc. Location - City of                  | r Town, Stete                       |  |  |
| Ĕ           | Pages<br>ment of<br>ent: If its<br>ury or o  |                | '4 □ Donation o □ Other (Specify  |                                  | 1   | norial Garde  | ns 01/28                                     | /2008                               | Olney, Man                              | yland                               |  |  |
| Balt        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or liems 23a or 28a-f show any finity or other traumatic avent, the Medical Examiner must be notified at ODGs. |                | 21. Signature of uneral Service Ligan   | See Trail                        | H   | 2. Name and Address<br>ines-Rinaldi<br>1800 New Ham                   | Funeral Ho                                   |                                     | r Spring. M                             | arvland 20904                       |  |  |
| ø           | 100  |                | 23a. Part1. Enter the disease, or companies shock, or heart fail te. List only  | olications that cause            | d the death. Do not en                            |   |  |                                     |   | Approximate<br>Interval Between     |  |  |
| 28          | Physician  |                | fmmediate Cause (Final disease or condition   | CORO                             | NADY  | PRIFRY  | 11517  | ASK                                 |   | Onset and Death                     |  |  |
|             | /Medical   |                | resulting in death)   | Due to (or as                    | a consequence of):                                | 1 1   | 0  |                                     | 67.                                     |                                     |  |  |
|             | Examiner   |                | Sequentially list conditions,   | CON                              | 665712  | E HER   | PRTF   | AILU                                | RE                                      |                                     |  |  |
|             | sit Bd   | ner            | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as                    | a consequence of):                                |   |  |                                     |   |                                     |  |  |
|             | ecute<br>and<br>trans  | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last   | C                                |   |   |  |                                     |   |                                     |  |  |
| 60,         | The law requires that the death certificate be executed tto has been signed by the attending physician and bage 2 should be detached for use as the burial-transit   | E              |   | Due to (or as                    | a consequence of):                                |   |  |                                     |   |                                     |  |  |
| 8760        | icate be ex<br>physician<br>the buria  | dlcal          |   | d                                |   |   |  |                                     |   |                                     |  |  |
| 9 X         | ath certific<br>attending p<br>for use as  | Physician/Me   | IF FEMALE:  | 23c. If yes, outcome             | of pregnancy                                      |   |  |                                     | 23d. Date of d                          | elivon                              |  |  |
| Вох         | atten<br>for u   | clan           | in the past 12 months?  |                                  | 2 Fetal death 3                                   | ☐Ectopic pregnancy<br>☐ Other (specify)                               |  |                                     | Month                                   | Day Year                            |  |  |
| o.          | at the de<br>by the a<br>tached  | ıysı           | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9□ Unknown                       |   |   |  |                                     |   |                                     |  |  |
| ٥.          | res that<br>igned b<br>be deta   | by Pt          | Part II. Other significant conditions of  | entributing to death t           | out not resulting in the u                        | ınderlying cause givei  | n in Part I.                                 | 23e. Did toba                       | icco use contribute                     | to the cause of death?              |  |  |
| Records,    | n sign   |                |   |                                  |   |   |  | 1 🗆 Yes                             | 2 No 3 1                                | Probably 4 Unknown                  |  |  |
| CO          | s been si<br>s should  | Completed      |   |                                  |   |   |  | 24a. Was an                         | 24b. Were                               | autopsy findings available          |  |  |
|             | The lav  | mo             |   |                                  |   |   |  | autopsy<br>performe                 | ad2 death                               | o completion of cause of<br>as 2 No |  |  |
| Vitai       |  | 0              | 25. Was case referred to medical  |                                  |   |   | 26. Place of Death                           |                                     |   | 2 2 140                             |  |  |
|             | Physician:<br>this certific<br>al director,  | To B           | examiner? 1 Yes 2 No  | Hospital:                        | ent 2 ER/Outpatie                                 | Other   | . /  |                                     | ce 6 □Other (Sp                         | ecify)                              |  |  |
| 0           | ding Ph<br>h.<br>After th<br>funeral   |                | 27. Manner of Death 1 Natural 5 ☐ Pending   | 28a. Date of Inju<br>(Month, Da  | ury 28b. Time o                                   | of 28c. Injury<br>Work  | at 2   | 8d. Describe how                    |   |                                     |  |  |
| 0           | uttendir<br>death.<br>ctor: Af<br>y the fur  | atlc           | 2 Accident investigation  |                                  | ,           |   | es 2 No                                      |                                     |   |                                     |  |  |
| Division of | after death<br>after death<br>Diractor:<br>I in by the   | Certification: | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of In<br>building, e  | jury - At home, farm, st                          | reet, factory, office   | 2  | 8f. Location (Stre<br>City or Town, | et and Number or i<br>State)            | Rural Route Number,                 |  |  |
|             | itel or<br>irs afte<br>rel Dir<br>lled in  |                |   |                                  |   |   |  |                                     |   |                                     |  |  |
|             | To the Hospital or Attending Physician: within 24 hours after deals.  To the Funerel Director: After this certific completely filled in by the funeral director,   | Medical        | (Check only 2 Medical Exam  | iner: On the basis of            | of my knowledge, deal<br>of examination and/or in | h occurred at the time<br>vestigation, in my opi                      | e, date and place, a<br>inion, death occurre | nd due to the cau                   | ise(s) and manner<br>e and place, and d | as stated.<br>ue to the cause(s)    |  |  |
|             | thin 2<br>thin 2<br>or the   | Med            | 29b. Signature and title of certifier   | and manner st                    | ated.   | 29c. License  | number                                       | 290                                 | d. Date signed (Mo                      | nth, Day, Year)                     |  |  |
|             | E 3 E 8  |                | Poullario   | Vilu                             | un H.D  | カ   | 3543   | 6                                   | 1 ANULAI                                |                                     |  |  |
| 1           | 0  |                | 20 Norma and address of   | ompleted sames of                | dayle Hom 22a Co.                                 | Printh 4  |  | 0                                   | 11100111                                | EY 27, 2008<br>EMD 20851            |  |  |
|             |  | 13             | 30. Name and address of person who c  | ompleted cause of                | tealt (Item 23a) (Type                            | 21 HON  | TROSE.                                       | RD. Ru                              | CKVILL                                  | EMD PERSI                           |  |  |
|             | Sta  | te             | 31. Date filed (Month, Day, Year)   |                                  | rar's Signature                                   |   | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,      | 0/11                                |   | 1.70-070                            |  |  |
| 3           | Registr  |                | JAN 29 200  | 18 18004                         | U. B. An  | we  |  |                                     |   |                                     |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State amend #5 Per FH G877 3/28/08 Obstificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Helen Grundstein Rosen 2008 8:50AM 28 /Medical Jan. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5204 Wyoming Road Bethesda Montgomery If Under 24 Hrs. Hours Min. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 281 714 1020 89 Director Nov.16, 1918 Ashland, Ohio 287-14-1020 Usuar Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Me-fical Examiner must be notified at Director MD Montgomery Bethesda 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5204 Wyoming Road 20816 Funeral United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Attorney Law es 1 and 2 should be filed w of Health and Mental Hygier f Item 27 is marked other th ir other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Samuel Grundstein Sophie Messing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Howard Rosen/Husband 5204 Wyoming Road Bethesda, MD 20816 permit. Pages 1 a
Department of Hec
Important: If Item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State National Crematory Falls Church, VA 4 Donation 5 Dother (Specify) 01/29/2008 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licenses 5230 Wisconsin Ave., NW Washington, DC 20016 23a. Part1. Enter the disease, o shock, or heart failure. Lis complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each me. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive Heart Failure 1 Month disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 5 Years Aortic Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of Examiner death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 🖾 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy performed? page ; certificate 1∐ Yes 2√2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2√ No 1 Inpatient this ို 2 ☐ ER/Outpatient 3 ☐ DOA After thi 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 XNatural 5 Pending within 24 hours arter common to the Funeral Director; Aft investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

31. Date filed (Month, Day, Year) JAN 29 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

D07147

29d. Date signed (Month, Day, Year)

01/28/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2/1/08 CMH Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Physician Year Keese 0301AM /Medical 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anap Arundel Medical Conter Anne Arundal Aurufo(s)
If Under 1 Year | If Under 24 Hrs. Anna 8. Date of Birth (Month, Day, 7/1)/1915 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Days Hours 1 X M 2 □ F Ohio 281-05-9004 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ☐Yes YX No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 Silverwood Circle 21403 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 232 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist EW Bliss 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mvrtle UNK 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Reese 425 Glenview Ct. Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Cemetery 1/30/2008 | Davidsonville, MD 21. Signature of Funeral Service 22. Name and Address of Facility Hardesty Funeral Home, P.A. 10 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician pernatremi /Medical Due to (or as a consequence of): Examiner ardiste Sequentially list conditions, if any, seaming to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical dvati IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day Year 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be dei 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 Yes 2 No 3 Probably 4 Unknown Completed Urinari 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Seizure certificate perform 1□ Yes 2 No funeral director, 25. Was case referre medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 01-27-2008 Monus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center, Annapolis, MD 21401 Michelle I homas MD HAME Arundel

State Registrar Zar)o

gistrar's Signature

ORIGINAL\*

State Registrar

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S Signature

Frain Highway

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** BARBARA SHIFFLETT 02 06 2008 1830 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2∏F Director Pottsville, PA 232**–**72–7505 Oct. 4,1946 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County Examiner must be notified at 1 ☐ Yes 2X No Director Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Hickory Knoll-Pine Swamp Road 26726 USA 14. Race - American Indian, Black, White, etc. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: ģ Specify: 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications Operator Telecommunications permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked oth any linjury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evan Opal Taylor <u>Mary Imilda Nagg</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamica A. Fertig/Daughter 441 N. Main Street Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb. 9 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) The Cumberland Crematory 2008 Cumberland, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Smith Funeral Home 85 S. Main Street THAN TSULL Keyser, WV 26726 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or s a consequence of): Septic Shock Sequentially list conditions if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (d as a consequence of Examine Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 KNo Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 □Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပို 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No

/Medical Examiner or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

28a-f show

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al Hygiene.

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within 24 hours after death

To the Funeral Director; A

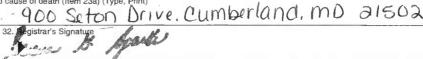
Certification: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature an 29d. Date signed (Month, Day, Year) tle of certifier

State

30. Name and

Steven Smith m.D 31. Date filed (Month, Day, Year)

2008



dress of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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State Registrar

31. Date filed (Month, Day,

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DHMH 17 Rev 1/2001

Cumberland MI) 21502

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

| (          |  |                 | 1 - For<br>State<br>Registrar  | State of Mar   |  | artment of F                                 |   | ental Hygie                               | 2000   | 04208                            |
|------------|--|-----------------|--|--|--|--|---|---|--|----------------------------------|
|            | Physici  | an              | 1. Decedent's Name (First, Middle, Last)   | Anna Rut   | h Seibert                              |  |   | 2. Date of Death<br>Month                 | Day Year                                     | 3. Time of Death                 |
|            | /Medi<br>Examir  |                 | 4a. Facility Name (If not institution, give s  |  |  | 4b. City, Town, o                            | r Location of Death                             | Feb.                                      | 5, 2008<br>4c. County of Death               | 6.00                             |
|            | LAGIIII  | ici             | Washington County  |  |  |  | gerstown  |   | Washing                                      | ton                              |
|            | Funeral  |                 | 5. Social Security Number 6. Sex   | 7. Age (   | In yrs. last birthday)                 | If Under 1 Year<br>Months Days               |   | 8. Date of Birth<br>(Month, Day, Ye       |  | place (State or Foreign<br>ntry) |
|            | Director   |                 | 220-40-0771  | M 2 F 5  | 95 Yrs.                                | World Days                                   |   | Sept. 4,                                  |  | aryland                          |
|            | and **   |                 | Usual Residence of Decedent  10a. State 10b. County  | 10   | 0c. City, Town or Lo                   | cation                                       |   |   | 1  | 10d, Inside City Limits          |
|            | iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | tor             | Maryland Washingt  |  |  | mithsburd                                    | 7   |   |  | 1 □Yes 2 No                      |
|            | or 28g   | Funeral Directo | 10e. Street and Number   |  |  | 10f. Zip Code                                |   | 10g.                                      | Citizen of What Cou                          | ntry?                            |
|            | 23a c  | la [            | 13402 Sandstone  | Drive  |  | 2.   | 1783  |   | U.S.A.                                       |                                  |
|            | r dea  | ne              |  | 12. Was Decedent Eve<br>Armed Forces?                                  | er in U.S. 13. V                       | Vas Decedent of H                            | lispanic Origin? (Spec<br>an, Mexican, Puerto F | cify Yes or No-<br>lican, etc.)           | 14. Race - Americ<br>Black, White,           |                                  |
| 36         | rs afte  | y Fu            | 1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 No If Yes, Give Year or Dates;                               |  | I□Yes 2√□No                                  | Specify:  | ,   | Specific                                     | hite                             |
| 5-0036     | thou<br>atura  | pe              | 15. Decedent's Educ  | ation  | 16a. Deced                             | lent's Usual Occup                           | pation  | 168                                       | b. Kind of Business/In                       |                                  |
| 215        | within 72<br>ene.<br>than "na<br>he Medic  | Completed by    | (Specify only highest grade  | College (1-4or 5+)   | (Give<br>life. L                       | kind of work done<br>OO NOT use retire       | during most of working<br>d)                    | g   |  | ,                                |
| 21         | filed withi<br>I Hygiene.<br>other than<br>ent, the M  | Con             | 8  |  |  | Homemake                                     |   |   | Home   |                                  |
| Maryland   | be file<br>at oth<br>even  | Be              | 17. Father's Name (First, Middle, Last)  |  |  |  | 18. Mother's Name                               |   | ,  |                                  |
| yla        | should be to a Mental I is marked or umatic eve  | ပ္              | Walter John Mi   |  | 40: 44: ":                             |  | <u> </u>  | Elizabetl                                 |  |                                  |
| Mai        | d 2 sho<br>th and<br>7 Is ma<br>trauma   |                 | 19a. Informant's Name/Relationship (Type Constance J. Beard  | •  |  |  | and Number or Rural                             |   |  | ,                                |
|            | 1 and 2<br>Health<br>tem 27 l  |                 | 20a. Method of Disposition   |  | 20b. Place of Dispos<br>cemetery, cren |  | Road Hager:                                     | ite 200                                   | Location - City or To                        |                                  |
| Baltimore, | Pages<br>nent of f<br>int: If ite  |                 | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)  | emoval from State  | smithsbu                               |  | , , , , ,                                       | ruary                                     | -  | , Maryland                       |
| alti.      | + Frais  |                 | 21. Signature of Funeral Service License   | e  |  | . Name and Addre                             |   |   | Funeral                                      | -                                |
| õ          | Depar<br>Impol<br>any ir   |                 | Toller los I   | Davis M  | 0/2//2/ 12                             | 2525 Brac                                    | lbury Ave.                                      |   |  |                                  |
|            |  |                 | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on   | cations that caused the  |  |  |   |   |  | Approximate<br>Interval Between  |
|            | Physician<br>/Medical  | 8 1             | Immediate Cause (Final disease or condition resulting in death)  | Ospi   | onsequence of):                        | Pres   | none  | •   |  | Onset and Death                  |
|            | Examiner   |                 | Conversation line constitutions  | Res  | luciu                                  | o de   | dan   |   |  | yeours.                          |
|            | p #  | iner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | Due to (or as a) o   | onsequence of):                        |  |   |   |  |                                  |
| V          | ate be executed hysician and the burial-transit  | Examiner        | Cause (Disease or injury that initiated events resulting in death) Last  | Due to /or or or   |  |  |   |   |  |                                  |
| 8760,      | be ex<br>cian a  | E               | and a second sec | Due to (or as a co   | onsequence or):                        |  |   |   |  |                                  |
| 87         | ficate<br>physi<br>s the b   | dical           | d.   | -  |  |  |   |   |  |                                  |
| Box 6      | death certifica<br>attending ph<br>for use as t  | /Me             | IF FEMALE: 23  | 3c. If yes, outcome pf p   | pregnancy                              |  |   |   | 23d. Date of deliv                           | One                              |
| ă          | death certificate be executed<br>e attending physician and<br>of for use as the burial-transit   | Physician/Med   | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No   | 1 ☐Live birth 2 ☐<br>4 ☐ Pregnant at tim                               | ☐Fetal death 3 ☐                       | Ectopic pregnancy<br>Other (specify)         | У   |   | Month Month                                  | Day Year                         |
| P.0.       | res that the de<br>signed by the a<br>be detached f  | hysi            | 9 ☐ Unknown  | 9□Unknown  |  |  |   |   |  |                                  |
| S,         | gned be det  | by P            | Part II. Other significant conditions conf   | tributing to death but n   | not resulting in the un                | derlying cause giv                           | en in Part I.                                   | 23e. Did tobac                            | co use contribute to t                       | he cause of death?               |
| rd         | v require<br>been sig<br>should b  | edt             |  |  | ····                                   |  |   | 1 ☐ Yes                                   | 2 No 3 Prol                                  | bably 4 Unknown                  |
| Records,   | 38<br>2  | plet            |  |  |  |  |   | 24a. Was an autopsy                       |  | ppsy findings available          |
|            |  | Completed       |  |  |  |  |   | performed                                 | l? death?<br>INo 1 ☐ Yes                     | 2 □ No                           |
| Vital      | i <b>ician:</b> Th<br>certificate<br>rector, pag   | Be (            | 25. Was case referred to medical examiner?   |  |  |  | 26. Place of Death                              |   |  |                                  |
| or         | Physi<br>this c  | ို              | I les 200  | ospital: Inpatient   | 2 ER/Outpatient                        |  | 4 L Nursing Hom                                 |   | e 6 □Other (Specia                           | fy)                              |
| nc<br>On   | ng<br>fter<br>iner   | io              | 27. Manner of Death  1 Natural 5 □ Pending   | 28a. Date of Injury<br>(Month, Day Y                                   | ear) 28b. Time of Injury               | 28c. Injur<br>Wor<br>M 1 □                   |   | 3d. Describe how i                        | njury occurred                               |                                  |
| Division   | vtteng<br>death<br>ctor:<br>y the  | icat            | 2 Accident investigation 3 Suicide 6 Could not be  | 28e. Place of injury   | - At home, farm, stre                  |  | Yes 2 □ No                                      | Rf Location /Stree                        | t and Number or Run                          | al Route Number                  |
| Div        | affer affer I Dire   | Certification:  | 4 ☐ Homicide determined  | building, etc. (   | Specify)                               | ,      |   | City or Town, S                           | tate)  | arrioute Number,                 |
|            | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu  | Medical C       | 29a. Certifier (Check only one) 1 Certifying Physical Examin   | ician: To the best of n<br>er: On the basis of ex<br>and manner stated | amination and/or inv                   | occurred at the tile<br>restigation, in my o | me, date and place, a<br>opinion, death occurre | nd due to the caus<br>d at the time, date | e(s) and manner as s<br>and place, and due t | stated.<br>o the cause(s)        |
|            | To the within 2. To the complet  | Me              | 29b. Signature and title of certifier  |  |  | 29c. Licens                                  | e number  | 29d.                                      | Date signed (Month,                          | Day, Year)                       |
|            |  |                 | Illeuseu g   | that   | 368                                    | 12   | 28365   |   | 2-6  | -08                              |
|            | 6  |                 | 30. Name and address of person who cor   | mpleted cause of death   | h (Item 23a) (Type, F                  |  |   | 200 . 14 -                                | MOZ  |                                  |

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 10:20 am SCHRADER 2008 reb /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Hospital Hanes 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 233-52-3563 1 M 2 □ F Months Days Hours Min Director ESTYRGINIA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Funeral Director ALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2015 HAMMONDS P 13-A Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. Armed Follows 1 No 1 Yes 2 No 1f Yes, Give Year or Dates: 1951-53 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WhITE Specify: Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RUSSELL SCHWADER ANIEMD. 2106 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State SYKESVI 4 Donation 5 Dother (Specify) Name and Address of Figility
Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Approximate Interval Between Onset and Death Part1. Enter the disease shock, or heart failure. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Atheroscleratic cardiovascular unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 9□Unknown Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an HUDEFTENSION autopsy nerform To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1, Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 R/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and making stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and little of certifier 29c. License number 00533/-2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Avenue; Baltimore MO 21229 31. Date filed (Month, Day, Year) egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 3:10 Florette C. Simister January 24 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17429 Avenleigh Drive Ashton Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🔼 F 215-33-6700 Director 82 April 25, 1925 Jamaica Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show at notified 1 ∏Yes 2 KNo Director Maryland Montgomery Ashton death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Examiner must be 23a 17429 Avenleigh Drive 20861 U.S.A. Funeral Items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 6 Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: þ 3 X Widowed 4 ☐ Divorced Black. 'natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) within ...
i. in marked other than "-"
I traumatic event Elementary/Secondary (0-12) College (1-4or 5+) 12 **Housewife** Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 1 Health and Mental ၉ Aaron Charles Anna Watson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other tr Paulette Delapenha - Daughter 17429 Avenleigh Drive, Ashton, Maryland 20861 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Norbeck Memorial Park 02/02/2008 Olney, Maryland —22. Name and Address of Facility

Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a Part1 Immediate Cause (Final disease or condition resulting in death) Physician Myocardial Infarction 1 hour /Medical Due to (or as a consequence of) Examiner Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Diabetes burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical Hypertension the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1☐Yes 2☐No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? S Q 1 Yes 2 No 3 Probably 4 XUnknown Hypercholesteremia Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Carotid Stenosis 24a. Was an page 2 s autopsy performed certificate Stroke 1□ Yes 2 X No Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 🖪 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Puneral Director; 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mn Mashid D39372 January 24, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rashid Baghai Naini, M.D., 344 West University Blvd., Suite #324, Silver Spring, Maryland 20901 egistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

30

JAN

2008

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2:40 a M **Physician** 2008 January Abraham Santilhano ·\*/Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Collingswood Nursing Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 6 Sex 5. Social Security Number Days **Funeral** Months Holland 1 🕱 M 2 🗆 F 7,1929 **February** 78 Director 579-50-9281 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State show 1 ☐Yes 2 X No ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Rockville Montgomery Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20853 13507 Grenoble Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ♣ No Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Completed 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Owned Bakery Shop Baker 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Sibelina Salverda Abraham Santilhano 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13507 Grenoble Drive, Rockville, Maryland 20853 Rosalie K. Santilhano - Wife item 27 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 01/30/2008 Rockville, Maryland Parklawn Memorial Park 5 ☐ Other (Specify) 4 Donation 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Lice -11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death leath Do not enter the mode of dying, such as cardiac or respiratory arrest, sease, or complications that caused the ilure. List only one cause on each line. 23a. Part1. Enter the diseas shock, or heart milure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed and -trans Due to (or as a consequence of) physician ar P.O. Box 68760, Physician/Medical as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery use 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Live birth Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? res 2 No has 1□ Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3 DOA 2 ☐ ER/Outpatient 1 | Inpatient 1 Yes 2 No Certification: To After this 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident neral Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide or / To the , within 24 hours.
To the Funeral D' 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certification D0062435 Medico Cata D. Rockville, MD 20850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 30 2008 Registrar

|                     |   |                | For<br>State<br>Registrar   |  | of Marylan   |   | artment of I  |   | Mental Hy                                | Reg. No.  | 08                           | 04212   |  |  |
|---------------------|---|----------------|---|--|--|---|---|---|--|---|------------------------------|---|--|--|
| ı                   | Physic<br>/Medi   |                | 1. Decedent's Name (First, Mid<br>Elaine  | B. Smith   |  |   |   |   | 2. Date of De<br>Month<br><b>January</b> | Day   | Year                         | 3. Time of Death 5:18 aM                          |  |  |
|                     | Exami   |                | 4a. Facility Name (If not institution 10100 Langhorn  |  |  |   | ]   | or Location of De<br>Bethesda   |  | 4c. County  | of Death                     | у   |  |  |
| Pin.                | Funeral<br>Director   |                | 5. Social Security Number  080-24-2758  | 6. Sex<br>1 ☐ M 2 🗷 F                                      | 7. Age (In yrs. 76   | last birthday)<br>Yrs.                  | If Under 1 Year<br>Months Days  | If Under 24 H<br>Hours Mi   |  | ay, Year)   | 9. Birthpl<br>Coun           | ace (State or Foreign<br>try) New York            |  |  |
|                     | uryland<br>show<br>d at   | _              | Usual Residence of Decedent  10a. State 10b. Coun   | ty   | 10c. City  | y, Town or Lo                           | cation  |   |  |   | 10                           | 0d. Inside City Limits                            |  |  |
|                     | the Ma<br>28a-f s   | Director       | Maryland Mon  | itgomery   |  |   | Bet<br>10f. Zip Code  | hesda   |  | 10g. Citizen of   | Mark Ones                    | 1 ☐ Yes 2 🗷 No                                    |  |  |
|                     | a or st be n  |                | 10100 Langhorn  | e Court  |  |   | Tot. Zip Code   | 20817   |  |   | J.S.A.                       | IF <b>y</b> ?                                     |  |  |
| 920                 | n 72 hours after death with the Maryland<br>"natural", or items 23a or 28a-f show<br>adical Examiner must be notifiled at   | by Funeral     | 11. Marital Status  1 Never Married 2 Na Ma 3 Nidowed 4 Divorce   | 12. Was Dec<br>Armed F<br>arried 1  Yes                    | 2 🔀 No<br>ive  |   | Was Decedent of I<br>If Yes, specify Cub<br>1 ☐ Yes 2 2 No                    | Hispanic Origin?<br>pan, Mexican, Pu  | (Specify Yes or No<br>erto Rican, etc.)  |   | ce - America<br>ck, White, e |   |  |  |
| Maryland 21215-0036 | ges 1 and 2 should be filed within 72 ho<br>it of Health and Mental Irygiene.<br>If item 27 Is marked other than "natur<br>or other traumatic event, the Medical. | Completed      | 15. Decede<br>(Specify only high<br>Elementary/Secondary (0-12)   | ent's Education<br>nest grade completed)  College (        |  | 16a. Dece<br>(Give<br>life.             | dent's Usual Occu<br>kind of work done<br>DO NOT use retire<br><b>Homem</b> a | during most of w  | vorking                                  | 16b. Kind of B  | usiness/Ind                  |   |  |  |
| pq 5                | e filed<br>al Hyg<br>other<br>vent, 1   | BeC            | 17. Father's Name (First, Middle  | e, Last)   |  |   |   | 1   | ame (First, Middle                       |   |                              |   |  |  |
| ylaı                | ould b<br>Menta<br>arked<br>atic e  | To             | Morris Bud  |  |  |   |   |   | Anna G                                   | umowitz   |                              |   |  |  |
| Mar                 | d 2 sh<br>th and<br>7 Is m<br>traum   |                | 19a. Informant's Name/Relation  Robert Smith  |  |  |   |   |   |  |   |                              | Code)   |  |  |
| nore,               | permit. Pages 1 and 2<br>Department of Health a<br>Important: If item 27 Is<br>any injury or other tra  |                | 20a. Method of Disposition 1   Burial 2 □ Cremation   | n 3 <b>⊠</b> Removal from                                  | State Zob. P   | lace of Disno                           | sition (Name of<br>natory or other pla  | ace)  | Date                                     | 20c. Location   | - City or To                 |   |  |  |
| Baltimore,          | permit. P. Departme Important any injury once.  |                | 4 □ Donation 5 □ Other 21. Signature of Funeral Service   |  | Mei  | I                                       | 2. Name and Addre<br>lines-Rinal  | ess of Facility<br>di Funera  | 27/2008<br>1 Home, Inc                   |   |                              |   |  |  |
|                     | Physician   |                | 23a. Part1. Inter the disease, shoot, or heart failure. Li Immediate Cause (Final disease or condition                            |  | caused the death   | n. Do not ent                           |   | Maryland 20904  # Hampshire Avenue, Silver Spring, Maryland 20904  # dying, such as cardiac or respiratory arrest, Interval Between Onset and Death  13 years |  |   |                              |   |  |  |
|                     | Physician<br>/Medical<br>Examiner   |                | resulting in death)  Sequentially list conditions.  | Due to   | (or as a consequ   | uence of):                              |   |   |  |   |                              |   |  |  |
|                     | executed and all-transit  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last | <b>S</b> c   | (or as a consequ   |   |   |   |  | Iver Spring, Maryland 20904  Approximate Interval Between Onset and Death |                              |   |  |  |
| 68760,              | ficate be executed<br>physician and<br>sthe burial-transit  | edical E       |   | d  |  |   |   |   |  |   |                              |   |  |  |
| O. Box              | the death certif<br>y the attending<br>iched for use as   | Physician/M    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🔼 No 9 ☐ Unknown   | 1 ☐ Live   | itcome pf pregna<br>birth 2  Fetal<br>nant at time of do<br>nown | Ideath 3□                               | Ectopic pregnanc<br>Other <i>(specify)</i>                                    | у   |  | I   |                              | ,   |  |  |
| rds, P.             | w requires that the de<br>been signed by the a<br>should be detached  | <u>م</u>       | Part II. Other significant condi  | tions contributing to d                                    | leath but not resu   | ulting in the u                         | nderlying cause gi  | ven in Part I.  |  |   |                              | e cause of death?                                 |  |  |
| or Vital Records,   | The lay<br>ate has<br>page 2  | Completed      |   |  |  |   |   |   | 24a. Was<br>auto<br>perfo                | psy<br>ormed?   | prior to con<br>death?       | psy findings available inpletion of cause of 2 No |  |  |
| Vita                | Physician: Th<br>this certificate<br>ral director, pag  | Be             | 25. Was case referred to medic examiner?  | Hoenital:  |  | ======================================= | Otl   | ner:  | eath <i>Check onl</i>                    |   |                              |   |  |  |
| ion or              | ling<br>After<br>fune   | ation: To      | 1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pend 2 ☐ Accident inves   | 28a. Date  | of Injury oth, Day Year)   | 28b. Time of<br>Injury                  | 28c. Inju   | 4 L Nursing   | 28d. Describe                            | idence 6 Oth<br>how injury occur  |                              | )   |  |  |
| Division            | tal or Atters after de al Directo   | Certification: | 3 Suicide 6 Could 4 Homicide deter  | mined   28e. Place   | e of injury - At ho<br>ling, etc. <i>(Sp</i> ec <i>it</i> y      | me, farm, str                           | eet, factory, office  |   | 28f. Location (<br>City or To            | Street and Numb<br>wn, State)   | oer or Rurai                 | Route Number,                                     |  |  |
|                     | To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the  | Medical        | 29a. Certifier 1 ★ Certify (Check only one)   | ring Physician: To the<br>al Examiner: On the b<br>and mar | e best of my know<br>pasis of examination<br>oner stated.        | wledge, deatl<br>tion and/or in         | vestigation, in my  | opinion, death oc   | ce, and due to the<br>curred at the time | cause(s) and m<br>, date and place,                                       | anner as st<br>and due to    | ated.<br>the cause(s)                             |  |  |
|                     | ĭĎ<br>P∰Z®  | M              | 29b. Signature and title of certif  | ier  | Dete-  |   | 29c. Licens   | 7158  |  | 29d. Date signe   |                              |   |  |  |
|                     | 10  |                | 30. Name and address of person  |  |  |   |   | Washingto   | on, D.C. 2                               | 20037   |                              |   |  |  |
|                     | Sta<br>Registi  |                | 31. Date filed (Month, Day, Yea   | r) 2. F  | Registrar's Signal   | ture                                    |   |   |  |   |                              |   |  |  |

Registrar

Babak Razi, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month LOREN WALLACE SARD 8:41 PM M JANUARY 22 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death TALBOT HOSPICE HOUSE EASTON TALBOT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1**X** M 2□ F 86 Director 1921 220-12-1069 APR 18, MARYLAND Usual Residence of Decedent 10a, State 10c, City, Town or Location 10h County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 ▼No EASTON TALBOT MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 10215 THREE BRIDGE BRANCH ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE 'natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FARMER AGRICULTURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Be 1 and 2 should be 1 Health and Mental ROLAND SARD MARTHA TALLEY 19a. Informant's Name/Relationship (Type. Print)
GEORGE W. MIDDLETON, JR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Department of Health a Important: If item 27 is any injury or other trau 12567 OLD SKIPTON ROAD, CORDOVA, MD 21625 GRANDSON-IN-LAW Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ■ Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 1-26-2008 EASTON, MARYLAND SPRING HILL CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facil FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Joseph M. Ostrowski C.F.S. 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) aro 16/1VO716 7/1/ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a sonsequence of): Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Yes 2 10 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 KOther (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Division or Vital Records, P.O. Box 68760,

After this Director: filled in by

To the

10

Certification: To 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MATIN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EGLSEDER III M.D. 503 CYNWOOD DRIVE, EASTON, MD 21601 LUDWIG J.

filed (Month, Day, Year) JAN 2 5 2008

1 Natural

32. Registrar's Signature

(Month, Day Year)

State Registrar

|                     |   |                              | 1 - For<br>State<br>Registrar   | State of I   | Maryland / Depa<br><i>Ce</i>  | artment o                                    | of Health<br>of Death                           | and Mer                          |                                  | ene<br>g. No. 20             | 08                       | 04215  |
|---------------------|---|------------------------------|---|--|---|--|---|----------------------------------|----------------------------------|------------------------------|--------------------------|--|
|                     | Physic  |                              | 1. Decedent's Name (First, Middle, La   | ,  | Tw  |  |   |                                  | Date of Death<br>Month           | Day                          | Year                     | 3. Time of Death                             |
|                     | /Medi<br>Exami  |                              | James Washington  4a. Facility Name (If not institution, given  |  |   | 4b. City. Toy                                | n, or Location                                  |                                  | anuary                           | 27, 20                       |                          | 10:12 A M                                    |
| -                   | LAGIIII   | iei                          | 8468 Bussenius Ro   |  |   | Pasad  |   | OI Death                         |                                  | Anne                         |                          |  |
|                     | Funeral   |                              | 5. Social Security Number 6. 9  |  | Age (In yrs. last birthday)   | If Under 1 Y                                 | ear If Under                                    |                                  | Date of Birth                    |                              |                          |  |
|                     | Director  |                              | 216-18-6895   | <b>X</b> M 2□F   | 83 Yrs.   | Months D                                     | ays Hours                                       | Min. (                           | Month, Day, 1                    | Year)<br>1924                | Mary                     | place (State or Foreign<br>ntry)<br>1 and    |
|                     | p .   |                              | Usuel Residence of Decedent   |  |   |  |   | 1 100                            | 11y 10,                          | 1727                         | TIGE y                   | Tand   |
|                     | how   |                              | 10a. State 10b. County  |  | 10c. City, Town or Lo   | ocation                                      |   |                                  |                                  |                              |                          | 10d. Inside City Limits                      |
|                     | Ba-f  | cto                          | MD Anne Aru   | ndel   | Glen Burn   | ie   |   |                                  |                                  |                              |                          | 1 ☐ Yes 2 No                                 |
|                     | 를 다.<br>6 22 원  | Director                     | 10e. Street and Number  |  |   | 10f. Zip Co                                  | de  |                                  | 10                               | g. Citizen of                | What Cou                 | ntry?  |
|                     | 23a   | a                            | 24 Virginia Avenu   | e NW   |   | 21061  |   |                                  | US                               | SA                           |                          |  |
| 36                  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland<br>Department of Health and Mental Hygiene.<br>Importent: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show<br>any injury or other traumatic event, the Medical Examinar must be notified at<br>ance. | by Funeral                   | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced   | 12. Was Decede<br>Armed Force<br>1X1Yes 2[<br>If Yes, Give<br>Year or Date | s?<br>∐No   | Was Decedent<br>f Yes, specify<br>1 ☐ Yes 2X | of Hispanic Or<br>Cuban, Mexical<br>No Specify: |                                  | Yes or No-<br>n, etc.)           |                              | ck, White,               |  |
| ŏ                   | 2 hou   |                              | 15. Decedent's E  | ducation   |   | dent's Usual O                               | ccupation                                       |                                  | 14                               | 6b. Kind of B                | Whi                      |  |
| 215                 | n' n' n' n' n' n' n' n' n' n' n' n' n' n  | Completed                    | (Specify only highest gra<br>Elementary/Secondary (0-12)  |  | (Give   | kind of work d<br>DO NOT use re              | one during mos                                  | at of working                    | '                                | SD. Paris Or D               | u3111033#111             | dustry                                       |
| 2                   | d with  | E                            | 12  | College (1-4d  |   | ess Own                                      | ner   |                                  | Т                                | 'elevis                      | sion                     | Repair                                       |
| þ                   | oth oth   | Be C                         | 17. Father's Name (First, Middle, Last  |  |   |  |   | er's Name (Fir                   |                                  |                              |                          |  |
| ylar                | ould by<br>Menta<br>Marked  | ToE                          | James Washington  |  |   | -  | !   | Bluche                           |                                  |                              |                          |  |
| Maryland 21215-0036 | d 2 sh<br>th and<br>t7 ls m<br>traum  |                              | James E. Stanley,   | • • • •  |   |  | reet and Number<br>Ave. N                       |                                  |                                  |                              |                          | Code)  |
| ā,                  | 1 an<br>Heal<br>Heal  |                              | 20a. Method of Disposition  | 524, 55  |   |  |   | Date                             | -                                | Oc. Location -               |                          | own State                                    |
| ĕ                   | nt of<br>nt of<br>t: If if  |                              | 1 ☐ Burial 2XX Cremation 3 ☐  |  | 20b. Place of Dispo<br>cemetery, cren                                 |  | I   |                                  |                                  |                              |                          |  |
| Baltimore,          | it. P<br>rtme<br>rten<br>njury  | 1                            | 4 Donation 5 Other (Special 21. Signature of Funetal Service Light  |  | Chesapeak   |  |   |                                  |                                  | ltsvil                       |                          |  |
| Ba                  | Dep<br>Imp  |                              | Barry la P H  | 1) the   |   |  | ddress of Facilion Crei                         |                                  |                                  |                              |                          |  |
|                     | Physician<br>/Medical   |                              | 23a. Part 1. Enter the disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)   | a. 37  | MO1251 B ed the death. Do not enter line.  POKE as a consequence of): | everly<br>er the mode of                     | L. HEC<br>dying, such as                        | cardiac or res                   | piratory arres                   | CLarks                       | SVIII                    | Approximate Interval Between Onset and Death |
| 1                   | Examiner  |                              | Consentative for a small train  |  | HURE T  | ונד ט  | PIVE  |                                  |                                  |                              | 13                       | 11004/                                       |
| 8760,               | cate be executed<br>physicien and<br>the burial-transit   | dical Examiner               | Sequentially let conditate if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or a   | is a consequence of):   | my S   | tenes   | 15                               |                                  |                              |                          | lyeon  |
| P.O. Box 687        | death certifi<br>e ettending<br>d for use as  | Completed by Physician/Medic | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | a  | 2 Fetal death 3   | Ectopic pregna<br>Other (specify             |   |                                  |                                  | 23d. Dat                     | e of delive              | ery<br>Day Year                              |
|                     | requires thet the<br>een signed by the  | Y P                          | Part II. Other significant conditions of  | ontributing to death   | but not resulting in the un   | derlying cause                               | given in Part I.                                |                                  | 23e. Did toba                    | cco use conti                | ribute to th             | ne cause of death?                           |
| Records,            | quire<br>n sig<br>uld b   | P P                          | Castrointer   | linal ble  | eding (low)   | (29  |   |                                  | 1 🗆 Yes                          | 2 🗆 No                       | 3 Prob                   | ably 4 Danknown                              |
| ပ္ပ                 |   | lete                         | Company   | nolem  | disease   |  |   |                                  | 24a. Was an                      | 24h \                        | Nore auto                | ncy findings evalable                        |
| Re                  | sician: The law<br>certificate hes t<br>irector, page 2 s   | E                            |   | 4,613  | ansense   |  |   | —   '                            | autopsy<br>performe              | dy c                         | leath?                   | psy findings available inpletion of cause of |
| Vital               | an:<br>tiffice<br>for, p  |                              | 25. Was case referred to medical  |  |   |  | 00 81   |                                  |                                  | No 1                         | Yes                      | 2 <b>1</b> /No                               |
| >                   | Physician:<br>this certific   | To B                         | examiner?<br>1 ☐ Yes 2 ☑ No   | Hospital:  | tient 2 ER/Outpatient   | 3□ DOA                                       | Othor   | of Death (Ch                     |                                  | - ATTOU                      |                          | , exwife's home                              |
| Division of         | Jing Pt<br>After th<br>funeral  |                              | 27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation   | 28a. Date of In<br>(Month, D   |   | 28c. I                                       | njury at<br>Work?                               |                                  | Describe how                     |                              |                          | 7) 01 10 11 13 11 13                         |
| Divi                | To the Hoepital or Attend within 24 hours after death To the Funerel Director: completely filled in by the  |                              | 3 ☐ Suicide 6 ☐ Could not be determined   | building,  | njury - At home, farm, stre<br>etc. <i>(Specify)</i>                  |  |   |                                  | City or Town, S                  | State)                       |                          | l Route Number,                              |
|                     | To the Hoepital or within 24 hours afte To the Funeral Dir.   | Medicai                      | 29a. Certifier 1 Certifying Ph<br>(Check only one) 2 Medical Exam   | rsician: To the besiner: On the basis and manners                          | t of my knowledge, death<br>of examination and/or inv<br>stated.      | occurred at the<br>estigation, in m          | e time, date and<br>ny opinion, deat            | d place, and d<br>th occurred at | ue to the caus<br>the time, date | se(s) and ma<br>and place, a | nner as st<br>and due to | ated.<br>the cause(s)                        |
|                     | To To To To To To To To To To To To To T  | 2                            | 29b. Signature and title of certifier   | ) 4  |   |  | ense number                                     |                                  |                                  | . Date signed                |                          |  |
|                     | 11.1  |                              | - (llum A)  | Madara   | Ma MO   | D  | 30 30   | 9166                             |                                  | 1-2                          | 8-2                      | Roos   |
|                     | 4+1   |                              | 30. Name and address of person who o  | ompleted cause of  | de (tem 23a) (Type, F   | Print)                                       | ) L A C   | ر ؛ حات                          | 0.01                             | . D.                         |                          | 1068<br>40 21061                             |
|                     | Sta   | e                            | 31. Date filed (Month, Day, Year)   | 000 32.  | MII NUX LA<br>trar's Signature  | NUMMA  | K DIL   | 1112                             | 8, Gle                           | n.Buh                        | 118,1                    | 11) - 106/                                   |
|                     | Registra  | ar                           | JAN J U Z   | UUO A  | in D. A.  | المتصافحا                                    |   |                                  |                                  |                              |                          |  |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2008 8:30 A William January 29, Turner Byrne 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince Frederick Calvert 6039 Daybreak Drive If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday Hours Days 1 ☑ M 2 □ F 11-25-1926 81 <u>216–</u>22–1590 Wash., D.C. Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2√7 No Prince Frederick MD Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20678 USA 6039 Daybreak Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1945–46 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2√2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) property owner/manager warehouse leasing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Aquila Turner Emily Blanche Kemper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6039 Daybreak Drive, Prince Frederick, MD 20678 Evelyn C. Turner, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gard. 02-02-2008 Waldorf, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final C disease or condition resulting in death) Due to (or as a consequence of): proman Sequentially list conditions, if any, leading to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on, reo Telew Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? le

Physician /Medical Examiner

**Physician** 

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events.

/Medical

Director

Funeral

Completed by

Be

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the burial-tra aftending physician for use as the buria been signed by the should be detached has le 2 , page certificate dire

law requires that the death certificate be executed

P.O. Box 68760.

Division or Vital Records,

Examiner Physician/Medical Completed by Be P After th funeral Certification: Director: 124 hours af

|   |                                |           |  |                        |         |   |     | Yes 2   | No 3 Probably 4 Unknow   |
|---|--------------------------------|-----------|--|------------------------|---------|---|-----|---|--|
|   |                                |           |  |                        |         |   |     | 24a. Was an autopsy performed? 1 Yes 2 ★No      | 24b. Were autopsy findings availab<br>prior to completion of cause o<br>death?<br>1 □ Yes 2 □ No |
| 25. Was case referr<br>examiner?<br>1 ☐ Yes 2 💢 | [                              | Hospital  | : 1 ☐ Inpatient 2 ☐                          | ] ER/Outpatient        | 3 🗆     | Othor   |     | Check only one) 5 Residence 6                   | □Other (Specify)   |
| 27. Manner of Death 1 ☑Natural 2 ☐ Accident     | 5 Pending investigation        |           | Date of Injury<br>(Month, Day Year)          | 28b. Time of<br>Injury | М       | 28c. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No                   | 286 | d. Describe how injury                          | occurred /   |
| 3 ☐ Suicide<br>4 ☐ Homicide                     | 6 ☐ Could not be<br>determined | 28e.      | Place of injury - At h building, etc. (Speci |                        | t, fact | ory, office   | 281 | f. Location (Street and<br>City or Town, State) | d Number or Rural Route Number,  |
|   |                                | niner: Or |  |                        |         | ed at the time, date and plaction, in my opinion, death occ |     |   | and manner as stated.<br>place, and due to the cause(s)  |

RW 10+1

the Hospital or Attending Physician:

hours after

the

State Registrar

Medical

29b. Signature and title of certifier

BROOKS

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signature 31. Date filed (Month, Day, 008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fh 9877 3-26-08vt. State of Maryland Poepartment of Health and Mental Hygiene Certificate of Death Reg. No. Z 1. Decedent's Name (First, Middle, Last)
Thomas Joseph Tereshinski Sr. 3. Time of Death 2. Date of Death 1/24/2008 Year 2210 M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Min. 1 M 2 □ F Months Days Hours 5/12/1921 86 ΈÀ 183-12-5979 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Anne Arundel Galesville 1 ☐ Yes 2 ₩ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20765 USA 4854 Church Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2KMarried 1 ▼ Yes 2 □ No WWII If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify. White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher High School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Tereshinski Sophia Radzyminski 19 Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) -Church Lane Mary Tereshinski Wife Galesville, MD 20765 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12 Burial 2 □ Cremation 3 □ Removal from State Quaker Burial Ground 1/29/2008 Galesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, Md 21401 Part Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Due ti (or as a consequence of): disease or condition Cheumoni resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events myasthen, Due lo (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

the death certificate be executed transi and the burial-Division or Vital Records, P.O. Box 68760. the attending physician ned for use as the buria by peen has certificate this After

signed by the be page rector. ġ. Hospital or Attending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu death.

Physician/Medical Completed Be P Certification: Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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ral", or items 23a or 28a-f shov Examiner must be notified at

s 1 and 2 should be filed within 72 hours after death via theath and Mental Hygiene. The marked other than "natural", or items 23s other traumatic event, the Medical Examiner must

parmit. Pages 1 a
Department of He
Important: If item
any Injury or othe

**Physician** 

Examiner

/Medical

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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the Maryland

with

29b. Signature and title of certifier

determined

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1/25/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AIAM

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2001 Medical Parkway Annapolis, MD 21401

31. Date filed (Month, Day, Year) JAN 2 9 2008 Registrar

4 ☐ Homicide

(Check only onel

29a. Certifier

amend line 19a per fd 01/28/08 aaco hlth dept dlw
8-00519 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00519 State of Maryland / Department of Health and Mental Hygiene amend lines 20a-corpore fd aaoo hith dept 01/31/08 differifficate of Death Cecelia Brown 2008 04219 Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day January 18, 2008 1100 hrs **Medical Examiner** Cecelia Brown Turner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 29 A Bens Drive Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days codMaryland Director **\$ept 25** 1956 51 217-72-6069 M 2 X F Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits Any 10a. State 10b. County 1 Xyes 2 No Annapolis or 28a-f show Maryland Anne Arundel hours after death with the Maryland Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 USA 29 A Bens Dr. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Armed Forces? 2 X No Yes 0 If Yes, Give Year Black Yes 2 X No specify. Divorced Specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry item 27 is marked other than "natur traumatic event, <u>the Me</u>dical Exam 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 nent of Health and Mental Hygiene. Mainstay Hotel Baltimore, MD 21215-0036 10th 0 House Keeping 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Chappin Be John Brown Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 19a Informant's Name/Relationship (Type, Print ) Ellinor Collins Annapolis, Md. 21403 Sister) B Marcs Ct. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date crematory or other place) X Durial 2 X Cremation 3 Removal from State 1-29-08 Grownsvil Baltimore Mo Lary, P.A. Donation 5 Other Specify. 27W Mange and Autosse Facility Sons Mortuary, 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 M. Recor M00483 Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Two Gunshot Wounds of Chest Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical the attending physician hed for use as the burial -UNPENDED AMENDED Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be deta ģ 1 Yes 2 V No 3 Probably 4 Unknown Records, P. Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of icate has b death? performed? certificate ✓ Yes 2 1 🗸 Yes 2 Νo Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be Hospital: 1 Other; Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene this 1 V Yes Certification: To 2 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Subject shot within 24 hours after death

To the Funeral Director: A
completely filled in by the fu Natural FOUND: Yes 2 V No Pending Jan 18, 2008 1050 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) 29 A Bens Drive, Annapolis, MD determined 4 V Homicide (Specify) Multi-Family Apt. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 19, 2008 ress person who completed cause of death (Item 23a) 30. Name and OCME Mary G//Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, 32. Registrar's Signature JAN 2 8 2008 Registra DHMH 17 Rev 1/2001

**OCME** 

OCME 2006

|  |                  | 1 - For State Registrar  |   | Cer                           | tificate of I                               | Death   | Re                                    | g. No.2 0 0 (               | 3 04220   |
|--|------------------|--|---|-------------------------------|---|---|---------------------------------------|-----------------------------|---|
| Physi  | cian             | Decedent's Name (First, Middle, Last,  |   |                               |   |   | 2. Date of Death<br>Month             | Day Yea                     |   |
| /Med<br>Exam   |                  | Wilson Edw 4a. Facility Name (If not institution, give   |   |                               | 4b. City, Town, or                          | r Location of Death                             | Jan                                   | 24 200<br>4c. County of De  |   |
|  |                  | Genesis HealthCa   |   |                               |   | ston  |                                       | Talk                        | oot   |
| Funera<br>Directo  |                  | 210-16-6008  | 7. Age (In yrs. I.<br>M 2□ F 85                                       | ast birthday)<br>Yrs.         | If Under 1 Year<br>Months Days              | If Under 24 Hrs.<br>Hours Min.                  | 8. Date of Birth (Month, Day, 04-28-1 | Year)                       | Birthplace (State or Foreign<br>Country)<br>aryland |
| yland<br>now<br>at   |                  | Usual Residence of Decedent  10a. State 10b. County  | 10c. City   | , Town or Loc                 | eation                                      |   |                                       |                             | 10d. Inside City Limits                             |
| ne Mar<br>8a-f st<br>ptified   | ctor             | Md. Talbot   | Mo  | Danie                         |   |   |                                       |                             | 1 □ Yes 2 No  |
| with the a or 2  | Funeral Director | 10e. Street and Number   |   |                               | 10f. Zip Code                               | 6.45  |                                       | g. Citizen of What          | Country?  |
| death<br>ms 23<br>r musi   | nera             | 9896 Old Clail   | 12. Was Decedent Ever in U.S<br>Armed Forces?                         | S. 13. V                      | 216<br>Vas Decedent of H                    | 5 4 /<br>ispanic Origin? (Span, Mexican, Puerto |                                       |                             | merican Indian,                                     |
| If I I I I I I I I I I I I I I I I I I   | by Fu            | 1 ☐ Never Married 2 ☐ Married 3 👿 Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 🗖 No<br>If Yes, Give  | - 1                           | Yes 2 No                                    | Specify:  | Rican, etc.)                          | Black, W Specify:           | hite, etc.  |
| 2 hour   | led b            | 15. Decedent's Edu<br>(Specify only highest grad   | Year or Dates:  | 16a. Deced                    | ent's Usual Occup                           | ation   | 1                                     | 6b. Kind of Busines         | Black<br>ss/Industry                                |
| ithin 72<br>ne.<br>nan "n  | Completed        | (Specify only highest grade<br>Elementary/Secondary (0-12)   | e completed) College (1-4or 5+)                                       | (Give I<br>life. D            | kind of work done of<br>O NOT use retired   | during most of work<br>d)                       | ing                                   |                             | •   |
| filed with Hygiene other tha   | ပ္ပ              | 17. Father's Name (First, Middle, Last)  | 2   | Mech                          | nanic                                       | 18. Mother's Name                               |                                       |                             | builders  |
| should be fund Mental I  | To Be            | Robert   | Trott   |                               |   | Henriet   | •                                     | ideout                      |   |
| 0 0 0  | -                | 19a. Informant's Name/Relationship (Ty   |   | 1                             |   | and Number or Run                               | al Route Number,                      | City or Town, State         |   |
| T, IV  1 and  Health  Eem 27   |                  | Nathaniel Trott  | 20h Pi  | lace of Dienos                | ition (Name of                              | , McDani  |                                       | yland 21                    |   |
| Pages<br>hent of the   |                  | 1 Denial 2 □ Cremation 3 □ F<br>4 □ Donation 5 □ Other (Specify)   | lemoval from State  | emetery, crem                 | natorý or other plac<br>Cen                 | ce)<br>(1.                                      | -                                     | ·                           |   |
| artiniti   |                  | 21. Signature of Funeral Service License   |   | 22.                           | Thomas Name and Addres                      | ss of Facility Be                               | nnie Sn                               | nith Fur                    | els,Md.<br>neral Home                               |
| and de de de de de de de de de de de de de   | 5                | Quesil.  | Took  |                               |   | r Street  |                                       | ·                           | 1   |
| Di di  |                  | 23a. Part1. Enter the disease, or complished, or heart failure. List only or<br>Immediate Cause (Final                           | ications that caused the death<br>ne cause on each line.              | 0                             |   | ig, such as cardiac o                           | or respiratory arres                  | st,                         | Approximate<br>Interval Between<br>Onset and Death  |
| Physiciar<br>/Medica   | 1                | disease or condition resulting in death)   | Due to (or as a c n qu  |                               | cer   |   |                                       |                             | Umos.   |
| Examine  |                  | Sequentially list conditions,  | ).  |                               |   |   |                                       |                             |   |
| uted<br>Insit  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter to derive Cause (Disease or injury that initiated events | Due to (or as a consequ   | ience of):                    |   |   |                                       |                             | a a   |
| execu<br>an and<br>rial-tra  |                  | resulting in death) Last   | Due to (or as a consequ   | ence of):                     |   |   |                                       |                             |   |
| rificate be executed by physician and as the burial-transit  | Aedical          |  | l   |                               |   |   |                                       |                             |   |
| ± Dog  | /Me              | IF FEMALE: 23b. Was decedent pregnant 2  | 3c. If yes, outcome pf pregnar  | ncy                           |   |   |                                       | 23d. Date of                | tolivon   |
| death ceri   | Physician//      | in the past 12 months?<br>1 ☐ Yes 2 ☑ No   | 1 ☐ Live birth 2 ☐ Fetal<br>4 ☐ Pregnant at time of de<br>9 ☐ Unknown |                               | Ectopic pregnancy<br>Other <i>(specify)</i> |   |                                       | Month                       | Day Year  |
| To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use | Phys             | 9 Unknown  |   | lting in the un               | dodicina acces aice                         | an in Dark I                                    | OCa Did take                          |                             | to the server of death 0                            |
| uires t  | d by             | Part II. Other significant conditions con  | 4.0   | -                             | denying cause give                          | en in Fait i.                                   | 1 A Yes                               |                             | to the cause of death?  Probably 4 □Unknown         |
| aw req   | olete            | Derch  | eral Vaso   | 0/                            | disease                                     |   | 24a. Was an                           | 24b. Were                   | autopsy findings available                          |
| The late ha  | Completed        |  |   |                               |   |   | autopsy<br>perform<br>1☐ Yes 2        | ed?   death                 |   |
| certific<br>rector,  | Be               | 25. Was case referred to medical examiner?   | lospital:   |                               | Othe  | 26. Place of Death                              |                                       |                             |   |
| g Physer this eral dii   | - 12<br>- 12     | 27. Manner of Death  | 28a. Date of Injury   | ER/Outpatient<br>28b. Time of | 3 DOA 28c. Injury                           | 4 De Nursing Ho                                 | me 5 Resider<br>28d. Describe hov     | nce 6 Other (Si             | pecify)   |
| ending<br>auth.<br>or: Aft   | atio             | 1 ☑ Natural 5 ☐ Pending<br>2 ☐ Accident investigation  | (Month, Day Year)   | Injury                        | <b>I</b>                                    | Yes 2 □ No                                      |                                       |                             |   |
| or Att<br>after de<br>Direct<br>in by t  | Certification:   | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of injury - At hor building, etc. (Specify                 |                               | et, factory, office                         |   | 28f. Location (Stre<br>City or Town,  | eet and Number or<br>State) | Rural Route Number,                                 |
| spital<br>nours a<br>neral<br>y filled   |                  | 29a. Certifier 1 Certifying Phys   | sician: To the best of my know  | vledge, death                 | occurred at the tim                         | ne, date and place,                             | and due to the car                    | use(s) and manner           | as stated.  |
| the Ho<br>nin 24<br>the Fu   | Medical          | one)   | ner: On the basis of examinati<br>and manner stated.                  | ion and/or inv                |   |   |                                       |                             |   |
| 0 = 0 5  | 2                | 29b. Signature and title of certifier  |   |                               | 29c. License                                | 1/2<87  |                                       | d. Date signed (Mo          | ,   |
| F > F 8  |                  | 1010   |   | 00-) /T F                     | larient)                                    | 10-01   |                                       | 01-25-                      | 6008  |
| 7  |                  | 30. Name and address of person who co  | impleted cause of death (Item   | 23a) (Type. F                 | 1111145                                     | 0 / 11  |                                       |                             |   |
| 2  |                  | 30. Name and address of person who co  | Schille ) 50  | 555                           | (gnwo                                       | JU DE   | GRSTV                                 | nMA                         | 21401   |
| 2  | tate<br>trar     | 30. Name and address of person who con PL V 5 SL V A .  31. Date filed (Month, Day, Year)  JAN 2 8 20                            | SChill 32. Registrar's Signati  | 555<br>ure                    | Gnwo  | JU DE   | Gasti                                 | n MD                        | 21401   |

DHMH 17 Rev 1/2001

|                     |  | ľ              | 1 - For<br>State<br>Registrar  | State of M   | laryland / [                           | -                  | rtment of H   |                               | nd Me                 |                               | giene                | HHK                           | 042                                       | 21        |
|---------------------|--|----------------|--|--|--|--------------------|---|-------------------------------|-----------------------|-------------------------------|----------------------|-------------------------------|---|-----------|
| £. 4                | Physici  | an             | 1. Decedent's Name (First, Middle, La.   |  |  |                    |   |                               | 2                     | 2. Date of Dea                | ath<br>Day           | Year                          | 3. Time of                                | Death     |
|                     | /Medic   | al             | 1110   | asel-  |  |                    |   |                               |                       | 1                             | 26                   | 2509                          | 9   | ى M       |
|                     | Examin   | er             | 4a. Facility Name (If not institution, give  | e street and number  | )                                      |                    | 4b. City, Town, or  | Location of                   | Death                 |                               |                      | County of Dea                 | 0 1                                       |           |
| - 85                | Funeral  |                | 5. Social Security Number 6. S   |  | ge (In yrs. last birt                  | thday)             | If Under 1 Year   | Under 2                       |                       | B. Date of Birti              | h                    | 9. Bir                        | thplace (State of                         | r Foreign |
| ne.                 | Director   |                | 014-14-2854  | □M 21X F   | 92                                     | Yrs.               | Months Days   | Hours                         | Min.                  | 04/23/1                       | 915                  |                               | ountry)<br>achusetts                      | 5         |
|                     | and  |                | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City, Town                        | n or Loc           | ation   |                               |                       |                               |                      |                               | 10d. Inside Ci                            | ty Limits |
|                     | Maryl<br>-f sho  | tor            | Maryland Anne Aru  | nde1   | Annapo                                 | lis                |   |                               |                       |                               |                      |                               | 1 ☐ Yes                                   | ·         |
|                     | h the  | Director       | 10e. Street and Number   |  |  |                    | 10f. Zip Code   |                               |                       |                               | 10g. Citiz           | zen of What C                 | ountry?                                   |           |
|                     | 23a c  | aiD            | 911 Topmast Way  |  |  |                    | 21401   | -                             |                       |                               | Unit                 | ted Sta                       | ites                                      |           |
|                     | be filed within 72 hours after death with the Maryland ital Hygiene. Id bygiene. Id other than "natural", or itams 23a or 28a-f show svent, I's Medical Exacilical most be notified at | Funeral        | 11. Marital Status 1 ☐ Never Married 2 ☐ Married   | 12. Was Deceden<br>Armed Forces<br>1 ☐ Yes 2 ☐             | ?                                      |                    | Vas Decedent of Hi<br>Yes, specify Cuba                         |                               | in? (Spec<br>Puerto R | ify Yes or No-<br>ican, etc.) | 1                    | 14. Race - Am<br>Black, Whi   | te, etc.                                  |           |
| 9                   | ei', or  | þ              | 3 Widowed 4 Divorced   | If Yes, Give X<br>Year or Dates:                           |  | 1                  | ☐ Yes 2Ã No   | Specify:                      |                       |                               |                      | Specify: Wh                   | ite                                       |           |
| -<br>-<br>-         | 72 ho  | Completed      | 15. Decedent's Ed<br>(Specify only highest gra   |  | 16a.                                   | Decede<br>(Give k  | ent's Usual Occupa<br>kind of work done of<br>O NOT use retired | ation<br>during most          | of working            | 9                             | 16b. Kir             | nd of Business                | /Industry                                 |           |
| [2                  | within<br>ene.<br>then   | mpi            | Elementary/Secondary (0-12)  | College (1-4or   |  |                    | o not use retired<br>emaker                                     | )                             |                       |                               |                      | Home                          |   |           |
| 2                   |  | e Co           | 17. Father's Name (First, Middle, Last)  |  |  | 1101110            | -maker  | 18. Mother                    | 's Name (             | First, Middle,                | Maiden .             |                               |   | -         |
| lan                 |  | To Be          | Fred O'Hara  |  |  |                    |   | Lena                          | Conwa                 | ay                            |                      |                               |   |           |
| Maryland 21215-0036 | d 2 should<br>th and Mer<br>?7 is marke<br>traumatic   | 1              | 19a. Informant's Name/Relationship (   |  | 19b.                                   | . Mailing          | Address (Street a   | and Number                    | r or Rural            | Route Numbe                   | r, City or           | Town, State,                  | Zip Code)                                 |           |
| e<br>E              | s 1 and<br>f Health<br>item 27<br>other to   |                | Henry T. Ulasek/H  | usband   | 91<br>20b. Place of                    | 1 To               | opmast Wa   | y, An                         | nario.                |                               |                      | and 214<br>cation - City or   |   |           |
| Baltimore,          | 00   |                | 1X Burial 2 ☐ Cremation 3 ☐  |  | ,                                      |                    | ition (Name of atory or other place                             | 1                             |                       |                               |                      |                               |   |           |
| 불                   | permit. Pag<br>Deportment<br>Important: f<br>any injury o  |                | 4 □ Donation 5 □ Other (Specification 21. Signature of 5 never 1 Section 1)  |  | Our Lady                               |                    | Sorrows Ce  | m. U                          | 1/30/                 | 2008 _                        | West                 | River                         | , MD                                      |           |
| ñ                   | Dep<br>Imp   |                | 1/1/1/100  |  |  | 29                 | 73 Solom  | ons Is                        | sland                 | Rd.,E                         | dgew                 | ater, l                       | MD 21037                                  | 7         |
| 32                  | Physician  |                | 23a. Part 1. Enter the disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition | plications that cause<br>one cause on each                 | ed the death. Do n                     | not ente           | r the mode of dying   | g, such as o                  | cardiac or            | respiratory ar                | rest,                |                               | Approximat<br>Interval Bet<br>Onset and I | ween      |
|                     | /Medical<br>Examiner   |                | resulting in death)  | Due to (o  | s a consequence o                      | of):               | 0.0   |                               |                       |                               |                      |                               | 1   |           |
|                     |  | er             | Sequentially list conditions, if any, leading to immediate   | b. Louis to for a  | a consequence of                       | مان                | Fach  | ne                            |                       |                               |                      |                               | 1-9                                       | 2         |
|                     | uted<br>d<br>ansit   | Examiner       | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events   |  | ·                                      | ,                  |   |                               |                       |                               |                      |                               |   |           |
| Ď,                  | ate be executed<br>hysician and<br>the burial-transii  | Exa            | resulting in death) Last   | Due to (or a   | s a consequence o                      | of):               |   |                               |                       |                               |                      |                               |   |           |
| 8/6U                | cate be executed<br>bhysician and<br>the burial-transit  | dicat          |  | d  |  |                    |   |                               |                       |                               |                      |                               |   |           |
| X<br>S              | death certifice<br>e attending pl<br>id for use as t   | /Me            | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcom-                                       | e of pregnancy                         |                    |   |                               |                       |                               | 2                    | 3d. Date of de                | livery                                    |           |
| EOX                 | 0 0 0  | Physician/Me   | in the past 12 months?   | 4□Pregnant a   | 2 Fetal death<br>at time of death      |                    | Ectopic pregnancy<br>Other (specify)                            |                               |                       |                               |                      | Month                         |   | /ear      |
| J<br>Ö              | at the<br>1 by th<br>stache  | Phys           | 9 Unknown  | 9 Unknown  |  |                    |   |                               |                       |                               |                      |                               |   |           |
| rds,                | law requires that the<br>as been signed by th<br>2 should be detache   | þ              | Part II. Other significant conditions of   | ontributing to death                                       | but not resulting in                   | the un             | derlying cause give   | en in Part I.                 |                       | 23e. Did to                   |                      |                               | o the cause of d<br>robably 4 🗆           |           |
| Hecord              | ie law requir<br>has been si<br>ge 2 should I  | Completed      |  | <u>-</u>   |  |                    |   |                               |                       | 24a. Was autop                |                      | 24b. Were a                   | utopsy findings<br>completion of c        | available |
| -                   | The<br>ate h<br>page   | Com            |  |  |  |                    |   |                               |                       | perfor                        | med?                 | death?                        | s 2 No                                    | uuu00 01  |
| Vital               | Physician: T<br>this certificat<br>ral director, p   | Be             | 25. Was case referred to medical examiner?   | Hospital:  |  |                    |   |                               | of Death (            | (Check only o                 | ne)                  |                               |   |           |
| 0                   | Phys<br>this<br>ral di   | . To           | 1 ☐ Yes 2 ☒ No  27. Manner of Death  | 28a. Date of Inj   |  | tpatient<br>ime of |   | 4 🗆 1901                      |                       | e 5 Resid                     |                      | Other (Spe                    | ecify)                                    |           |
| 0                   | Attending In death. sctor: After by the funer  | ation          | 1 Natural 5 ☐ Pending<br>2 Accident investigation  | (Month, D  | ay Year) ir                            | njury              | 28c. Injury<br>Work   | k?<br>Yes 2 □ N               |                       |                               |                      |                               |   |           |
| DIVISION            |  | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined  | 286. Place of Ir   | njury - At home, fai<br>atc. (Specify) | rm, stre           | et, factory, office   |                               | 28                    | of Location (S<br>City or Tow |                      |                               | tural Route Num                           | ber,      |
| _                   | Hospital or<br>24 hours afte<br>Funeral Dir<br>tely filled in  |                | 29a. Certifier 1 Certifying Ph   |  |  |                    |   |                               |                       |                               |                      |                               |   | - 1       |
|                     | Hospital of 24 hours at e Funeral D  | edicai         |  | ysician: To the bes<br>niner: On the basis<br>and manner s | of examination and                     | d/or inv           | estigation, in my or  | ne, date and<br>pinion, death | h occurred            | d at the time, o              | cause(s)<br>date and | and manner a<br>place, and du | s stated.<br>e to the cause(s             | )         |
|                     | To the Hos<br>within 24 h<br>To the Fun<br>completely  | Me             | 29b. Signature and title of certifier  | 0 4  |  |                    | 29c. License  |                               |                       |                               | 29d. Date            | e signed (Mon                 | th, Day, Year)                            |           |
|                     | N CO   | 4              | 1 Kgl  |  | 10                                     |                    | 200   | 6178                          | 3                     |                               | i                    | /26/0                         | 8   |           |
|                     | NOW.   |                | 30. Name and address of berson who   | 0.00.1   |  |                    |   | , bu                          | roxec                 | Les.                          | rei)                 | > 21                          | 10+                                       |           |
|                     | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)  JAN 2 8 2   | _  | rar's Signature                        |                    |   |                               | 0                     |                               |                      |                               |   |           |
|                     | negisti  | ai .           | JAN & O L  | UUU REM  | us the                                 | 1                  | ALL ALL   |                               |                       |                               |                      |                               |   |           |

|                         |   |                 |   | partment of Health and Nertificate of Death  |   | ene<br>2008                                     | 01,222   |
|-------------------------|---|-----------------|---|--|---|---|--|
|                         | ^   |                 | Decedent's Name (First, Middle, Last)   | ortinoate or Beath   | 2. Date of Death                                |   | 3. Time of Death                                   |
|                         | Physici<br>/Medi  |                 | Mary Frances Van Metter   |  | Jan.25  | 2008 Year                                       | 9:40p <sup>M</sup>                                 |
|                         | Examir  | ier             | 4a. Facility Name (If not institution, give street and number) 321 University Blvd W #224   | 4b. City, Town, or Location of Death Silver Spring   |   | 4c. County of Death<br>Montgo                   |  |
| 6.                      | Funeral<br>Director   |                 | 5. Social Security Number 6. Sex 1 M 2 M F 7. Age (In yrs. last birthd  | Months Days Hours Min  | 8. Date of Birth 2/10 / 1                       | 9. Birth  | place (State or Foreign<br>htry)<br>York           |
|                         | Maryland<br>I-f show<br>fled at   | tor             | Usual Residence of Decedent  10a. State   | Location<br>r Spring   |   |   | 10d. Inside City Limits 1 ☐ Yes 2 No               |
|                         | th the<br>or 28a<br>e noti  | Director        | 10e. Street and Number  | 10f. Zip Code  | 10g   | g. Citizen of What Cou                          | intry?   |
|                         | s 23a<br>nust b   | eral [          | 321 University Blvd.W #224  | 20901  |   | USA   |  |
| 900                     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral      | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No  If Yes, Give Year or Dates:   | <ol> <li>Was Decedent of Hispanic Origin? (Sp<br/>If Yes, specify Cuban, Mexican, Puerto</li> <li>□ Yes 2 X No Specify:</li> </ol> | ecify Yes or No-<br>Rican, etc.)                | 14. Race - Ameri<br>Black, White<br>Specify: W. |  |
| 5-0                     | יל 27 ר<br>"natu<br>edical  | letec           | 15. Decedent's Education 16a. De (Specify only highest grade completed) (G  | cedent's Usual Occupation<br>ive kind of work done during most of work<br>e. DO NOT use retired)                                   | ring 16   | 6b. Kind of Business/Ir                         | ndustry  |
| 21215-0036              | ed withir<br>/giene.<br>er than<br>t, the Me  | Completed       |   | Head Teller  |   | Bank  |  |
| Maryland                | ould be file<br>Mental Hy<br>arked oth  | To Be (         | 17. Father's Name (First, Middle, Last) Harry Sharkey   |  | e (First, Middle, Ma<br>eska Kot                |   |  |
| , Mar                   | and 2 sh<br>lealth and<br>m 27 is m<br>her traum  |                 | Richard VanMetter/Son 252   | ailing Address (Street and Number or Rur<br>Walnut St.N.W.   | Washingt  |   |  |
| Baltimore,              | . Pages 1<br>Iment of H<br>tant: If ite<br>jury or otl  |                 | 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify Fernc!  | iff Cem. 1/31  | /2008 H   | oc. Location - City or T<br>Hartsdale           | , N.Y.   |
| Ball                    | permit<br>Depart<br>Import<br>any in  |                 | 21. Signature of Funeral Service Life nee   | PHILIP D.RINALDI<br>924! Columbia B  | FUNERA  | L SERVIC  | E,P.A.<br>ng,Md2091                                |
|                         | Physician<br>/Medical   |                 | 23a. Pắrt1. Énter thể diséase, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. End stage rei | enter the mode of dying, such as cardiac   | or respiratory arrest                           | t,  | Approximate<br>Interval Between<br>Onset and Death |
| 8760,                   | icate be executed physician and physician and sthe burial-transit   | al Examiner     | Sequentially list conditions, if any, leading to in an edictic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Arterioscler  Due to (or as a consequence of):  c        | otic disease   |   |   |  |
| Ψ                       | h certificate<br>anding physuse as the  | in/Medical      | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy   |  |   | 23d. Date of deliv                              | ery  |
| .O. B                   | that the death certifi<br>ed by the attending I<br>detached for use as  | by Physician/Me |   | 3 ∐Ectopic pregnancy<br>5 ☐ Other (specify)  |   | Month   | Day Year   |
| rds, F                  | The law requires that the death certifit ite has been signed by the attending lage 2 should be detached for use as  | ed by P         | Part II. Other significant conditions contributing to death but not resulting in the hemodialysis   | underlying cause given in Part I.  |   | cco use contribute to t                         | he cause of death?                                 |
| Vital Records, P.O. Box |   | Completed       | dementia<br>hypertension  |  | 24a. Was an<br>autopsy<br>performe<br>1 Yes 2 € | 24b. Were auto<br>prior to co<br>death?         | opsy findings available<br>impletion of cause of   |
| Vita<br>V               | ysician; The is certificate hadirector, page  | Be              | 25. Was case referred to medical examiner?  |  | (Check only one)                                |   |  |
|                         | Phys<br>r this<br>ral dir   | ۲.              | 1 ☐ Yes 2 № No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat  27. Manner of Death 28a. Date of Injury 28b. Time   |  | me 5 X Residence<br>28d. Describe how           | ce 6 Other (Special                             | (y)  |
| Division or             | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director,   | Certification:  | 1 X Natural 5 ☐ Pending (Month, Day Year) Injur 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)   | / Work?<br>M 1 □ Yes 2 □ No  |   | et and Number or Run                            | al Route Number,                                   |
|                         | To the Hospital or within 24 hours after To the Funeral Discompletely filled in   | Medical Co      | 29a. Certifier (Check only one)  1 **Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.  | ath occurred at the time, date and place, investigation, in my opinion, death occur  | and due to the caus                             | se(s) and manner as s<br>and place, and due t   | stated.<br>o the cause(s)                          |
| )                       |   | Me              | 29b. Signature and title of certifier Rawert H. Llevare M. D.   | 29c. License number D0055522   | 29d.  | . Date signed (Month,                           |  |
|                         | 3   |                 | 30. Name and address of person who completed cause of death (Item 23a) (Type Robert H.Gerard MD 110 Irv.  | e, Print)<br>ing St.NW Washin  | gton,D.   | C. 20010  |  |
|                         | Sta<br>Registra   |                 | 31. Date filed (Month, Day, Year)  JAN 2 9 2008  32 egistrar's Signature  | boots  |   |   |  |

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|                                       |  |                | for State Registrar  | State of  | Marylaı                                   |                                  | artment of<br>rtificate of                                |                                   | nd Mental Hy                                 | giene<br>Reg. No. 200             | 8 04223  |
|---------------------------------------|--|----------------|--|---|---|----------------------------------|---|-----------------------------------|--|-----------------------------------|--|
| X                                     | Physic   |                | 1. Decedent's Name (First, Middle  |   |   |                                  |   |                                   | 2. Date of De<br>Month                       | eath<br>Day Ye                    | M  |
| 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | /Medi<br>Examir  |                | Giles Joseph  4a. Facility Name (If not institution)   |   | ber)                                      |                                  | 4b. City, Town,   | or Location of I                  |  | 4c. County of E                   | 2008 12:57p  |
| 2.00                                  | Funeral  |                | Montgomery Gene 5. Social Security Number  |   |   | . last birthday)                 | Olne If Under 1 Yea Months Days                           | r If Under 24                     | Hrs. 8. Date of Bin                          | th 9.                             | Ontgomery Birthplace (State or Foreign Country)    |
| 41                                    | Director   |                | 212-68-0576 Usual Residence of Decedent  | TIXW ZUF  | 80  | Yrs.                             |   | 710010                            |  | 1, 1927                           | India  |
|                                       | laryland<br>show   | J.             | 10a. State 10b. County   |   | 10c. C                                    | ity, Town or Lo                  | ocation   |                                   |  |                                   | 10d. Inside City Limits 1 ☐ Yes 2X No              |
|                                       | the Nr. 28a-f  | Director       | Maryland Mo<br>10e. Street and Number  | ntgomery  |   | Silv                             | er Sprin  | g                                 |  | 10g. Citizen of Wha               |  |
|                                       | th with  |                | 12426 Littleto   | n Street  |   |                                  |   | 2090                              | 06   | USA                               | 1  |
| 9                                     | s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It Health and Mental Hygiene. It is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | Funeral        | 11. Marital Status 1 ☐ Never Married 2 ☑ Marrie  | 12. Was Deced<br>Armed Ford<br>1 Tyes<br>If Yes, Give     | es?                                       |                                  | Was Decedent of<br>If Yes, specify Cu<br>1 ☐ Yes 2√2 No   |                                   | n? (Specify Yes or No<br>Puerto Rican, etc.) |                                   | merican Indian,<br>Vhite, etc.                     |
| 003                                   | hours<br>ural",  | d by           | 3 ☐ Widowed 4 ☐ Divorced   | Year or Dat   | es:                                       |                                  |   |                                   |  | Specify A S                       |  |
| Maryland 21215-0036                   | hin 72<br>e.<br>an "nat<br>Medica  | Completed      | 15. Decedent'<br>(Specify only highes<br>Elementary/Secondary (0-12)   | t grade completed)  College (1-                           | 4or 5+)                                   | Give                             | dent's Usual Occi<br>kind of work don<br>DO NOT use retir | ipation<br>e during most o<br>ed) | of working                                   | 16b. Kind of Busine               | ess/Industry                                       |
| 2                                     | filed wit<br>Hygiene<br>other tha  | Сол            |  | 5+  |   | E1                               | ectrical  | T -                               |  |                                   | Industry   |
| and                                   | d be fill set of ceven   | Be c           | 17. Father's Name (First, Middle, L<br>Cajeton Vaz   | _ast)   |   |                                  |   |                                   | s Name <i>(First, Middle</i><br>Lobo         | , Maiden Surname)                 |  |
| ary                                   | 2 should be f<br>and Mentail<br>Is marked of<br>aumatic eve  | To             | 19a. Informant's Name/Relationsh   | ip (Type. Print)  |   | 19b. Maili                       | ng Address (Stree   | 3                                 | or Rural Route Numb                          | er, City or Town, Sta             | te, Zip Code)                                      |
| Baltimore, M                          | o o <b></b> -  |                | Deborah Ide/Dau  20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation  |   | tate                                      | Place of Dispo<br>cemetery, cre- | sition (Name of<br>matory or other pl                     | ace)                              | ne, Silve<br>Date<br>Feb. 1,                 | r Spring.<br>20c. Location - City |  |
| E E                                   |  |                | 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L   | ecify)  | Me  |                                  | itan Cre  | matory                            | 2008   | Alexandri                         | a, Virginia  |
| Ba                                    | permit. Departr Importa any inju   |                | a ames   | 5000  | 7   |                                  |   |                                   | ins Funera                                   |                                   | c.<br>ring, MD 2090                                |
| 100                                   | Physician  |                | 23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) | only one cause on ea                                      | used the dea<br>ch line.                  | th. Do not en                    | er the mode of dy   | ring, such as ca                  | ardiac or respiratory a                      | rrest,                            | Approximate<br>Interval Between<br>Onset and Death |
|                                       | /Medical<br>Examiner   |                |  | Due to (o   | r as a consec                             |                                  | _//   | -/                                | 2 4  |                                   | han  |
|                                       | ecuted<br>and<br>I-transit   | Examiner       | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last      | c. Ath  | ras a consec                              | continue of                      | Can   | Liovaso                           | cular Di                                     | sense                             | year   |
| 68/60                                 | ficate be executed<br>physician and<br>sthe burial-transit   | dical          |  | d   |   | 4401100 01),                     |   |                                   |  |                                   |  |
| C. Box                                | at the death certific<br>by the attending p<br>tached for use as   | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  |   | th 2□Fetant at time of o                  | al death 3□                      | Ectopic pregnan<br>Other (specify)                        | су                                |  | 23d. Date of<br>Month             | delivery<br>Day Year                               |
| ت.<br>ت                               | s that t<br>ned by<br>e detac  |                | Part II. Other significant condition   | ns contributing to dea                                    | th but not res                            | sulting in the u                 | nderlying cause g   | ven in Part I.                    | 23e. Did t                                   | obacco use contribut              | e to the cause of death?                           |
| ecords                                | w requires that<br>been signed b<br>should be deta   | ted by         |  |   | -   |                                  |   |                                   | 1  | Yes 2□No 3□                       | Probably 4 Donknown                                |
| r                                     | The law<br>ate has b<br>page 2 sf  | Completed      |  |   |   |                                  |   |                                   | 24a. Was<br>auto<br>perfo<br>1∐ Yes          |                                   |  |
| VItal                                 | Physician:<br>r this certific<br>ral director,   | Be             | 25. Was case referred to medical examiner?   | Hospital:   |   |                                  |   | hor:                              | Death Check onl                              |                                   |  |
| o                                     | Phy<br>this  | n: To          | 1 Yes 2 No 27. Manner of Death   | 28a. Date of  | Injury                                    | 28b. Time o                      | 1 3 DOX   | 4 LI Nursi                        | ing Home 5 ☐ Resi<br>28d. Describe           | dence 6 Other (S                  | Specify)   |
|                                       | Attending F r death. ector: After by the funer   | atio           | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga   | ation   | Day Year)                                 | Injury                           |   | ork?<br>]Yes 2∐No                 | ,  |                                   |  |
| DIVISION                              | i diffe  | Certification: | 3 ☐ Suicide 6 ☐ Could no<br>4 ☐ Homicide determin  | of be ned 28e. Place o building                           | f injury - At h<br>j, etc. <i>(Sp</i> eci | ome, farm, str                   | eet, factory, office                                      |                                   | 28f. Location (<br>City or To                | Street and Number o<br>vn, State) | r Rural Route Number,                              |
|                                       | To the Hospital within 24 hours a To the Funeral I completely filled   | edical         | 29a. Certifier 1 Certifying (Check only one) 2 Medical E   | Physician: To the be<br>examiner: On the bas<br>and manne | is of examina                             | ation and/or in                  | vectination in my   | oninion doath                     | accourred at the time                        | data and place and                | due to the course(s)                               |
|                                       | To the within To the compl   | Me             | 29b. Signature and title of certifier  | 477   | Medi                                      | of Do                            | £ 29c. Licen  | se number                         |  | 29d. Date signed (M               | onth, Day, Year)                                   |
| 1                                     | 1  |                | Holath-  | ms  | Dept                                      | f EM                             | 100   | 50410                             | >  | 1/28/0                            | 8  |
|                                       |  |                | 30. Name and address of person w   | en mi   | 18701                                     | m 23a) (Type,                    | Print) Phil   | ip Dr.                            | O/ny   | 20133                             | b  |
|                                       | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)  | 2008  | istrar's Signa                            | ature                            | seles   |                                   |  |                                   |  |

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2:35 P M 26, James Joseph Vrabel 2008 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3093 Newington Drive Riva Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5/29/1935 Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) New Jersey **Funeral** Days Hours 1 XM 2 □ F 156-26-7528 Director 72 Usual Residence of Decedent works 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2XNo Director Anne Arundel Maryland Riva 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3093 Newington Drive 21140 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No Ir 7 ves, Give Year or Dates: 1958-59 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 vears Commercial Artist Commercial Art 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis E. Vrabel Catherine (unknown) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brian Vrabel/ Son 512 Terrace Drive, Island Lakes, NJ 07422 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Locust Hill Crematory 1/31/08 Dover, New Jersey 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility George P. Kalas Funeral Home Muly Enter the di-2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit the death certificate be executed Exami Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year 4□Pregnant at time of death signed by the a 5 Other (specify) 1 ☐ Yes 2 ☐ No 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of has e 2 r this certificate h death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA P 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50605 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Christie, M.D. 2661 Riva Rd., Ste. 610, Annapolis, Maryland 21401 31. Date filed (Month, Day, Year) State JAN 2 9 2008 Registrar

DHMH 17 Rev 1/2001

amend items 19a,b per fh g879 5-2-08 vt
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 11 per sister g878 4-30-08 vt
State of Department of Health and Mental Hygiene
1- State Amend PI line c perME,g877 3/12/08 TCertificate of Death
Reg. No. 2 0 0 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** DWAYNE WHITE 02 08 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Year)
Apr. 29,1959 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1**X** M 2 □ F 48 217-76-3848 Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ā r 28a-f sh notified a 1 ☐ Yes 2 No Director Allegany Maryland Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? th and Mental Hygiene. 7 Is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be 16125 McMullen Highway, S.W. 21502 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ÄYes 2 □ No If Yes, Give Year or Dates: 1 976-80 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married <del>2 ☑ M</del>arried 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ 3 ☐ Widowed 4 ♣ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) trucks, autos, Elementary/Secondary (0-12) College (1-4or 5+) master technician mechanic school buses 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Rosa Juanita Linney Charles Francis White 19a. Informant's Name/Relationship (Type. Print)
Carla J. Grantham
Lisa M. White - Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4317 Rolling Stone Way Alexandria, Va. 22306 16125 McMullen Highway S.W., Cumberland MD 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State All County Cremation 2/16/2008 Sykesville, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signatule of Funeral Service License al Marine () 404 S. Main St. Woodsboro, MD 21798 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Massive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hyperkelemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No SProbably 4 □Unknown Completed Alcold abuse 24b. Were autopsy findings available prior to completion of cause of death?
1 

Yes 2 □ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospnar C. within 24 hours after death.

To the Funeral Director: After an analytic filled in by the fur (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2/8/08 1240PM 066101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. CHEEMA, 900 SETON DRIVE CUMBERCUID, ND 21502 31. Date filed (Month, Day, Year) State FEB 1 3 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Norman Evans Walker January 24, 2008 2:30 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert County Nursing Center Prince Frederick Calvert 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 1**∑** M 2 □ F Director 578-14-7927 86 10/23/1921 Washington, D.C Usual Residence of Decedent the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MD Calvert Lusby 10e. Street and Number 10f. Zip Code ms 23a or 2 10g. Citizen of What Country? 50 Appeal Lane, Apt. #227 20657 1 and 2 should be filed within 72 hours after death wealth and Mental Hygiene. em 27 is marked other than "natural", or items 23: ther traumatic event, the Medical Examiner must Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. \$ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Industrial Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James E. Walker ဂ္ Mary Catherine Deparini 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other troones. Ruth M. Walker (Wife) 50 Appeal Lane, Apt. #227, Lusby, Maryland 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery | 02/01/2008 | Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION NEUMONIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ DISEASC OBSTRUCTIVE PULMONARY 1 Tes 2 No 3 Probably 4 Unknown Completed CARCINOMA OF 24a. Was an autopsy performed? 1☐ Yes 2 🗖 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 2 1 1 ☐ Yes 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 🗆 No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Errifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18W 8+1 Anwar T. Munshi, MD 110 Hospital Road, Suite 310, Prince Frederick, MD 20678

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Registra s Signature

DHMH 17 Rev 1/2001

|              |  |                     | 1 - For<br>State<br>Registrar  |  | Maryland /   |                             | artment<br>rtificate                     |                      |                                       |                            |                                 | Reg. No.                    | 2008  | 04228  |
|--------------|--|---------------------|--|--|--|-----------------------------|--|----------------------|---------------------------------------|----------------------------|---------------------------------|-----------------------------|---|--|
|              | Physic<br>/Medi  |                     | 1. Decedent's Name (First, Middle<br>James Glynn Woo   |  |  |                             |  |                      |                                       |                            | 2. Date of De<br>Month          | Day                         | Year<br>ZOCS                                | 3. Time of Death   |
|              | Exami  |                     | 4a. Facility Name (If not institution  |  | *  |                             | 4b. City, T                              |                      |                                       |                            |                                 |                             | unty of Death                               | _  |
| <u>. 4-</u>  | Funeral  |                     | Baltimore Washi 5. Social Security Number  |  | cal Cent<br>. Age (In yrs. last                                  |                             | If Under 1                               | Year                 | urnie<br>If Under 2                   |                            | B. Date of Bir<br>(Month, Da    |                             | 9. Birthp                                   |  |
|              | Director   |                     | 228-42-0514  | ¥XM 2□F  | 75   | Yrs.                        | Months                                   | Days                 | Hours                                 | Min.                       | Month, Da<br>112/1              | y, Yea <i>r)</i><br>932     | Coun<br>Vi                                  | lace (State or Foreign<br>try)<br>rginia                           |
|              | and w  |                     | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City, To  | own or Lo                   | cation                                   |                      |                                       |                            |                                 |                             | 1   | 0d. Inside City Limits   |
|              | Maryli<br>f sho<br>ied at  | jo                  |  | Arunde1  |  | mbri.                       |  |                      |                                       |                            |                                 |                             |   | 1 □ Yes 2√€ No   |
|              | r 28a  | irec                | 10e. Street and Number   | il ander   | Ga   | шиг                         | 10f. Zip (                               | Code                 |                                       |                            |                                 | 10g. Citizer                | of What Coun                                | try?   |
|              | 23a c<br>ust be  | la D                | 752 Annapolis R  | d.   |  |                             | 21                                       | 054                  |                                       |                            |                                 | US                          | SA  |  |
| 926          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.   | by Funeral Director | 11. Marital Status  1 ☐ Never Married 2 ☐ Marr  3 ☐ Widowed 4 ☐ Divorced   | Armed Fore   | <sup>2□No</sup> Kore   | a                           | Was Decede<br>f Yes, speci<br>1 □ Yes 24 |                      | spanic Orig<br>n, Mexican<br>Specify: | gin? (Speci<br>, Puerto Ri | fy Yes or No<br>ican, etc.)     |                             | Race - Americ<br>Black, White,<br>pecify: W |  |
| 21215-003    | 72 hornatur  | Completed           | 15. Decedent   | 's Education   | 1  | 6a. Deced                   | dent's Usual                             | Occupa               | tion<br>uring most                    | of working                 | 7                               | 16b. Kind                   | of Business/Inc                             | dustry   |
| 121          | vithin rine.   | mple                | Elementary/Secondary (0-12)  | College (1-  |  |                             | kind of work<br>DO NOT use               |                      | annig moor                            | or working                 |                                 |                             | 4 D-1-                                      |  |
|              | filed v<br>Hygie<br>other t  |                     | 17. Father's Name (First, Middle,  | Last)  |  | CORL                        | roller                                   |                      | 18. Mother                            | r's Name (                 | First, Middle                   |                             | rname)                                      | aging  |
| land         | lid be<br>fental<br>rked c   | To Be               | Joseph Lynwood   | Woody  |  |                             |  |                      | Luc                                   | y Nas                      | sh                              |                             | ,   |  |
| Mary         | 2 shot<br>and N<br>Is mai  |                     | 19a. Informant's Name/Relations  | nip (Type. Print)  | 1  | 9b. Mailin                  | g Address (                              | Street a             |                                       |                            |                                 | er, City or To              | own, State, Zip                             | Code)  |
|              | and<br>fealth<br>m 27<br>her tr  |                     |  | on   |  |                             | nnapol                                   |                      |                                       |                            | ills,                           |                             |   |  |
| Baltimore,   | ages 1<br>nt of H<br>: If Ite  |                     | 20a. Method of Disposition 1 △ Burial 2 □ Cremation  |  | late   |                             | sition (Name<br>natory or oth            |                      | 1                                     | Da                         |                                 |                             | ion - City or To                            | •  |
| Ħ,           | artme<br>ortant<br>Injury  | 3                   | 4 □ Donation 5 □ Other (S  | - A  | St.  |                             |  |                      |                                       |                            |                                 |                             | sville,<br>1 Home,                          |  |
| Ba           | Depar<br>Impol<br>any Ir   | 6 5                 | Dati A   | MI   |  |                             | 2 Ride                                   |                      |                                       |                            | apolis                          |                             |   | , F.A.   |
| 8760,        | Physician /Medical Examiner /Medical Examiner physician and physician and the pnial-transit physician and physician and physician physic | ical Examiner       | 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (o   | r as a consequent  | ce of):                     | Faih                                     | 0.                   |                                       | cardiac or                 | respiratory a                   | rrest,                      |   | Approximate<br>Interval Between<br>Onset and Death                 |
| P.O. Box 687 | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit   | Physician/Medic     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 1 ☐ Live bir   | ome pf pregnancy<br>th 2 □ Fetal de<br>nt at time of death<br>wn | ath 3□                      | ]Ectopic pre<br>] Other <i>(spe</i>      |                      |                                       | -                          |                                 | 23d                         | . Date of delive                            | ory<br>Day Year  |
|              | es that<br>igned b   | by Pł               | Part II. Other significant condition   | ns contributing to dea                                   | ath but not resulting  | g in the ur                 | nderlying car                            | ise give             | n in Part I.                          |                            |                                 | 37                          |   | e cause of death?  |
| Il Records,  |  | Completed           |  |  |  |                             |  |                      |                                       | _                          | 24a. Was auto perfo             | an 2                        | 24b. Were autoprior to condeath?            | ably 4 Unknown  psy findings available  npletion of cause of  2 No |
| Vital        | Physician: Th<br>r this certificate<br>ral director, pag   | Be                  | 25. Was case referred to medical examiner?   | Hospital:  |  |                             |  | Otho                 | ·-                                    |                            | Check only o                    |                             |   |  |
| Ö            | ding Ph<br>J.<br>After th<br>funeral   | ation: To           | 1 Yes 2 No  27. Manner of leath 1 Natural 5 Pendin 2 Accident investig   | 28a. Date of (Month                                      |  | Outpatien b. Time of Injury |  | c. Injury<br>Work    | 4 ∐ Nur                               | 28                         | e 5 ☐ Resid. Describe           |                             | Other (Specify                              | ()   |
| Division     | i di di  | Certification:      | 3 ☐ Suicide 6 ☐ Could r<br>4 ☐ Homicide determ   | ned 28e. Place of building                               | of injury - At home,<br>g, etc. <i>(Specify)</i>                 |                             |  |                      |                                       |                            | City or To                      | wn, State)                  |   | l Route Number,  |
|              | To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I  | Medical             | 29a. Certifier (Check only one)  | g Physician: To the t<br>Examiner: On the ba<br>and mann | sis of examination   | dge, death<br>and/or in     | occurred a vestigation,                  | t the tim<br>n my op | e, date and<br>inion, deat            | d place, ar<br>th occurred | nd due to the<br>d at the time, | cause(s) an<br>date and pla | d manner as st<br>ace, and due to           | ated. the cause(s)   |
|              | With Volume  | 7                   | 29b. Signature and title of certifier  |  |  |                             | 29c.                                     | License              | number                                | 7                          |                                 | 29d. Date s                 | igned (Month,                               | Day, Year)   |
|              | PQ /4.   | 7                   | Arom   | me   |  |                             | 4.                                       | 7                    | 17/                                   |                            |                                 | Jama                        | m 27  | 2008   |
|              | 4 Or   |                     | 30. Name and address of person   | who completed cause                                      | of death (Item 23  | a) (Type)                   | Print) CL                                | S. S.                | 10/20                                 |                            | 10 A                            | 20                          | 6   |  |
|              | Sta  | ate                 | 31 Date filed (Month, Day, Yea)  | 32. Re   | girar's Signature  | 400                         | , - , 40                                 | n                    | AM . A                                |                            | - M                             |                             |   |  |
|              | Regist   | rar                 | JAN 2  | 9 2008   | gigran's Signature   | K,                          | freel                                    | 1                    |                                       |                            |                                 |                             |   |  |
| DH           | MH 17 Rev 1/2  | 001                 |  |  |  | 0.01                        | OILLA                                    |                      |                                       |                            |                                 |                             |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended, 19b, FH \_ State TCHD, 1/28/2008, TLS Certificate of Death Reg. No. 🧷 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year 1910 PM Grace Beatrice Wayman January 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Memorial Hospital TAllbot EASTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04-24-1921 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Months Days Hours Maryland Director 86 213-22-9256 Usual Residence of Decedent death with the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show, any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Caroline Md. Denton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1015 Gay Street 21629 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify þ 3 Widowed 4 □ Divorced Specify. Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamtress Sewing Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Mason ပ Bessie Prattis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayman, William, Sr./ Son Denter Ma 21629 1015 Gay Street, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Veterans Cem. 02-01-08 4 Donation 5 Dother (Specify) Hurlock, Maryland 22. Name and Address of Facility Bennie Smith Funeral Home mature of F neral Service Licenses 426 Dover Street, Easton, Md. 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erebro vascular accident Days /Medical Due to (or as a consequence of) Examiner failure Days Renal 5 Just fielly file conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Year Dav 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed Failure Hearl-24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ★ npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD aunul D 66441 January 23 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Registrar JAN 2 8 2008

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There Is from

32. Registrar's Signature

WASHINGTON

STREET

MD

21601

EASTON

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Hattie Oliver Alexander 08:40 ™ /Medical February 5, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Thomas More Nursing Home Hyattsville Prince George's 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛛 F 105yrs. Director 248-34-6630 August 15,1902South Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland a or 28a-f show be notified at 10a. State 10c. City, Town or Location DC Yes 2□No Director Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a edical Examiner ⊓ust b 131 Bates Street NW Funeral 20001 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 □ Divorced Specify: Black the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Presser City Laundry 4th es 1 and 2 should be filed vol Health and Mental Hygie of Health and Mental Hygie fitem 27 is marked other tor other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sie Chesnut Charity Dix ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 a Department of Hee Important: If Item any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Cemetery 4 Donation 5 Dother (Specify) 2-14-2008 Camden, South Carolina 21. Signature of Fundal Service Licenses 22. Name and Address of Facility Marshall's Funeral Home of MD D. CRA 4308 Suitland Road, Suitland, MD 20746 23a. Part1. Buter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiac Arrythmia Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Atrial Fibrillation sician and burial-tran Due to (or as a consequence of): Physician/Medical the attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Progressive Cognitive Decline 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an page 2 s autopsy certificate 2**√** № 2**V** No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 X Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide e Funeral 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 21524 February 7, 2008

State Registrar Esmerando O.

31. Date filed (Month, Day, Year)

FEB 1 4 2008

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

1160 Varnum St. NE, Washington, DC 20017

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#32. Registrar's Signature

Juanitez, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 29d per dr., g876 02/14/08dhbeath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician**  $A^{\mathsf{M}}$ Mary Feb. 5, 2008 4:36 Apalucci /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4 Craftsman Court Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗙 F 48 Yrs. 1959 Maryland 215-80-8513 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a State 10b. County 28a-f show be notified at 1 ☐ Yes 2 X No Director Baltimore Reisterstown  $Md_{\bullet}$ 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 'natural", or Items 23a 4 Craftsman Court 21136 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bunting Alfred Drnec Jacqulin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Frank Apalucci/Husband 4 Craftsman Court Reisterstown, Maryland 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) 2/7/08 Towson, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA ASPIRATION Physician /Medical Due to (or as a consequence of): **Examiner** GASTROPARESIS DIABETIC Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi). Examine INSUZINI DEBENDENT DIRBETES or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by INSUFFICIENCY 1 Yes 2 No 3 Probably 4 Unknown COPD 2/ 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CHRINIC 6 f BAKUDATI ID certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ပု After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director.

completely filled in by the Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) State 2008 Registrar



17.1)

1 Certifying hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

32639

Sister Pierre Dr #204

29d. Date signed *Month, Day, Year)* 02/05/2008

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Donald William Adams, Sr. FEBRUARY 200 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GLEN tout SALTIMORE (DAKAHINGTON MEDICAL ( 5. Social Security Number 6. Sex 7. Age (In yrs. last b TEZ 8. Date of Birth (Month, Day, Year June 5, 1925 If Under 1 Year | If Under 24 Hrs. 5. Social Security Birthplace Country) **Funeral** Days XXM 2 F Yrs 82 Director 219-18-1842 Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2☐ No Director Glen Burnie MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 506 Marion Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examinen once. X⊠Yes 2 No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Foreman National Store Fixtures 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Susan Cox Duncan L. Adams, Sr. ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 506 Marion Rd., Glen Burnie, MD Wife Charlean Adams 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition t⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State CROWNSVILLE, MD CROWNSVILLE VET CEMETERY Feb 15, 2008 4 □ Donation 5 □ Other (Specify) e Funeral Service Lic 22. Name and Address of Facility
Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD Gregory Fink plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Part1 Enter the disease, or c, or heart failure. Lis Approximate Interval Between Onset and Death Immediate Cause (Final SEPS15 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 100 CARDITIC VALWE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the autopsy performe 2 No 2 No 1∐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) Marne and address of person wh hospital 31. Date filed (Month, Day, 32. Flegistrar's Signature (ear) State 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Robert Anthony Brumleve 2/8/2008 6:45  $P^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brinton Woods Nursing & Rehab. Center Carroll Winfield If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1[XM 2□ F 129-10 8794 **Director** 3/29/1920 Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2X No Director MD Carroll Mt. Airv 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Menlarl Hygene. In protrant: If them 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 any injury or other traumatic event, the Medical Examiner must be 1. 812 Parade Lane 21771 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates 1942-45 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed by White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Quinn Wholesale Co. Accountant 1 and 2 should be filed w fealth and Mental Hygier om 27 is marked other tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony Joseph Brumleve Mabel Florence Gill ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type. Print) 6607 Christy Acres Ct., Mt. Airy, MD 21771 Sarah Popa/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 urial 2 ☐ Cremation 3 ☐ Removal from State 2/16/2008 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cemetery Mt. Airy, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Burrier-Queen Funeral Home & Crematory, P.A. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiacor respiratory arrest, approximate or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 110 24a. Was an autopsy 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 TER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and major stated. 29a Certifier Medical 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1000 LIBARY RO ELDUSBIA NO 21784 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 14

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 11 2008 **Physician** Cecelia Bennett Catherine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore 925 Wampler Road Baltimore County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 11 1922 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 □ F 85 212 26 4149 Director Usual Residence of Decedent 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Funeral Director Baltimore County Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21220 USA 925 Wampler Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examiner once. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 Completed by 3 K Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping-Own Home NΑ Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Wednore Joseph Guthrie ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 925 Wampler Road Baltimore, Maryland 21220 Elizabeth Bennett 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery February 13 2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lassahn Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Road Baltimore, Maryland 21236 Immediate Cause (Final Physician DIGESTIVE disease or condition resulting in death) /Medical Due to (or as a conse unce of): Atheroscleros Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be execute anding physician and use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregpant 3 □Ectopic pregnancy for in the past 12 months? 5 ☐ Other (specify) ed by the a 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an page 2 autopsy 1□ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home Aresidence 6 Other (Specify) 1 Yes 2. No 1 Inpatient 2 □ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No nours after death.

neral Director; A
filled in by the fu 2 T Accident 6 ☐ Could not be

within 24 hours a

To the Funeral I

completely filled

To the Hospital

State Registrar 3□ Suicide

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

FEB

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+ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

29d. Date signed (Month, Day, Year)

23d. Date of delivery

Day

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

2:50 A M

Birthplace (State or Foreign
Country)

Baltimore City, MD.

14. Race - American Indian.

Black, White, etc.

Specify: White

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 □Yes 2 □No

2008

n who completed come of death (Item 23a) (Type, Print) 30. Name and address of pers

determined

Parkville

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HARREDAD Rel SUTTE E YTER 32. Registrar's Signa 31. Date filed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

**Funeral** Director 28a-f shov other traumatic event, the Medical Examiner must be notified at ітата 23а Maryland 21215-0036 al Hygiene. n and Mental H ed bluods Department of Health a important: If item 27 is eny injury or other tra-**Physician** /Medical Examiner The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, Hospital or Attending Physician:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a per verb., g8/6,02/14/08dhb Reg. No. 1. Decedent's Name (First, Middle, Last) B. Time of Death 2. Date of Death Day **Physician** Month Year 3008 Marion S. Butcher 1208 AM February 5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Loren - Bel Air Houford 7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year If Under 24 Hrs. Min. Days Hours Min. Day, Year)

Oct. 31, 1916 5. Social Security Number Birthplace (State or Foreign Country) 214-12-0215 1 □ M 2**X**□ F Maryland Usual Residence of Decedent 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Maryland Harford Bel Air 1 ☐ Yes 🌠 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1909 Emmorton Road Apt. 317 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sydney St. John Sappington Mary Boyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Sappington / Nephew 900 E. Broadway Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/9/08 Holy Redeemer Cem. Baltimore, Maryland 21. Signatury of Fu eral sice Licensee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md.21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final CEREBROVASCULAR ACCIDENT A CUTE disease or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of defivery 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILLATION, CORONARY ARTERY 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown HYPOTHYRDIDISM 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how infury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Securitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD D45344 Moura 02/05/2008

Registrar

State

After

Director:

thin 24 hours after To the Funeral Direct

death.

SURESA

31. Date filed (Month, Day, Year)

622 S. VALOW ANT, HAYRE DE GRACE MD2/078

30. Name and add person who my leted cause of death (Item 23a) (Type, Print)

MD

. Registrar's Signature

DHANJANI

2008

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|-------------------|--|------------------|---|--|---|--|---------------------------------------|-------------------------------|---|
|                   |  |                  | State     Registrar  1. Decedent's Name (First, Middle, Last)   | Ce   | rtificate of De                                   |  | Reg.                                  | No.                           | 3. Time of Death                                    |
| я                 | Physici  | an               |   | and W. Dai                                     | lau   | -  | Month                                 | Day 2/Year                    | 12:10 AM  |
| 1                 | /Medic   | 200              | 4a. Eacility Name (If not institution, give street and number)  | vard W. Bai                                    | 4b. City, Town, or Loc                            | cation of Death  | 02                                    | 4c. County of Deat            |   |
|                   | LAAIIIII   | CI<br>S          | Franklin Square, Huspi  | tal Center                                     | Rosed   | ale  |                                       | Balt                          | more  |
|                   | Funeral  |                  |   | e (In yrs. last birthday)                      |   | Under 24 Hrs. 8<br>lours Min.  | . Date of Birth<br>(Month, Day, Ye    | ar) 9. Birt                   | hplace (State or Foreign ountry)                    |
|                   | Director   |                  | 218-36-3722 1™ № 2□F  | 67 Yrs.  |   |  | Jan 13,                               | 1941                          | Maryland  |
|                   | land<br>ow<br>it   |                  | Usual Residence of Decedent  10a. State 10b. County   | 10c. City, Town or Lo                          | ocation   |  |                                       |                               | 10d. Inside City Limits                             |
|                   | Mary<br>Fied a   | ţ                | Maryland Baltimore  |  | Balt  | timore   |                                       |                               | 1 <b>□X</b> es 2 <b>□</b> No                        |
|                   | th the<br>or 28g   | )irec            | 10e. Street and Number  |  | 10f. Zip Code                                     |  | 10g.                                  | Citizen of What Co            | ountry?   |
|                   | ath wi   | ra [             | 945 Foxridge Lane   |  |   | 21221  |                                       |                               | S.A.  |
|                   | er dek<br>items<br>ner m   | Funeral Director | 11. Marital Status  1 □ Never Married 2 Married  12. Was Decedent Armed Forces?  1 □ Never Married 2 Married  | Ever in U.S. 13.                               | Was Decedent of Hispa<br>If Yes, specify Cuban, N | inic Origin? (Speci<br>Mexican, Puerto Ri  | fy Yes or No-<br>can, etc.)           | 14. Race - Ame<br>Black, Whit |   |
| 36                | irs aft<br>Il", or<br>xami   | by F             | 1 □ Never Married 2 M Married   | 10   | 1 □ Yes 2 🔁 🌭 S                                   | pecify:  |                                       | Specify:                      | Black   |
| 21215-0036        | filed within 72 hours after death with the Maryland<br>Hygiene.<br>vither than "natural", or items 23a or 28a-f show<br>ent, the Medical Examiner must be notified at  | ted              | 15. Decedent's Education (Specify only highest grade completed)   | 16a. Dece                                      | dent's Usual Occupation                           | n<br>na most of working  |                                       | . Kind of Business            | /Industry   |
| 218               | ithin 7<br>se.<br>san "r<br>Med  | Completed        | Elementary/Secondary (0-12) College (1-4or s  | life.  | DO NOT use retired)                               |  | -                                     | Indepen                       | dent Owned  |
|                   | led wi<br>lygier<br>her th<br>nt, the  |                  | 12. Tather's Name (First, Middle, Last)   |  |   | railer Driver<br>. Mother's Name (   | First Middle Mair                     |                               |   |
| Ä                 | d be fi  | Be               | Howard W. Gilbert   |  | 10.   | . Mother a reame (   |                                       | a Bailey                      |   |
| Maryland          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. | 유                | 19a. Informant's Name/Relationship (Type. Print)  | 19b. Maili                                     | ng Address (Street and                            | Number or Rural  |                                       |                               | Zip Code)   |
|                   | ind 2 salth all  |                  | Dondra L. Bailey Wife   |  | 945 Foxridge La                                   | ne Essex, M  | aryland 2122                          | 21                            |   |
| Baltimore,        | es 1 a of Her  |                  | 20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ Removal from State   | 20b. Place of Dispo                            |   | Dat  |                                       | . Location - City or          | Town, State   |
| Ě                 | Pag<br>ment<br>ant: I  |                  | 4 ☐ Donation 5 ☐ Other (Specify)  | Garrison I                                     | Forest Veterans                                   | DESCRIPTION OF THE PERSON OF T | 02/22/03                              | Owings                        | Mills, Md.  |
| 3alt              | permit. Departn Importa any inju   |                  | 21. Signature of Funeral Service Licensee   | //! 2  | <ol><li>Name and Address or</li></ol>             | f Facility   | al Carrian D                          | Δ                             |   |
|                   | ⊕ ⊓ = 16 O   | - 4              | 23a. Part1. Enter the disease, or complications that causer shock, or fear failure. List only one cause, or each light productions are supported to the cause of | the death Do not en                            | 1300 Eut  | otners Funer<br>aw Place Ba  | timore, Md 2                          | <del>21217</del>              | Approximate   |
| 0                 |  |                  | shock, or heart failure. List only one cause in each li   | ne.  | in Carra  | Lina   | oophatory arroot,                     |                               | Interval Between<br>Onset and Death                 |
|                   | Physician /Medical   |                  | disease or condition resulting in death)  | a consequence of): \                           | II HULL   | TIDY   |                                       |                               |   |
|                   | Examiner   |                  | ( Oxo   | nary   | neart o   | islage   | )                                     |                               |   |
| 7                 |  | ner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | a consequence of):                             |   |  |                                       |                               |   |
| /                 | ecutec<br>ind<br>transi  | Examiner         | Cause (Disease or injury that initiated events c  |  |   |  |                                       |                               |   |
| 60,               | icate be executed<br>physician and<br>s the burial-transit   | Ē                | Due to (or as   | a consequence of):                             |   |  |                                       |                               |   |
| 38760,            | icate<br>physi<br>s the b  | dical            | d   |  |   |  |                                       |                               |   |
| Box (             | reertif<br>nding<br>use as   | Physician/Me     | IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant  |  |   |  |                                       | 23d. Date of de               | livery  |
|                   | death<br>e atte  | icia             | in the past 12 months?  |  | □Ectopic pregnancy<br>□ Other (specify)           |  |                                       | Month                         | Day Year  |
| P.0               | at the<br>by the<br>tache  | hys              | 9 ☐ Unknown   |  |   |  |                                       |                               |   |
|                   | The law requires that the death certif<br>ate has been signed by the attending<br>page 2 should be detached for use as   | þ                | Part II. Other significant conditions contributing to death to  | ut not resulting in the u                      | ınderlying cause given i                          | n Part I.  | 23e. Did tobac                        |                               | o the cause of death?  robably 4 □Unknown           |
| or Vital Records, | w requir<br>been si<br>should  | Completed        | Diagenes incline  | 5  |   |  |                                       |                               | -   |
| 3ec               | e law<br>has b<br>je 2 sl  | mple             | Hypertension  |  |   |  | 24a. Was an autopsy performed         | prior to                      | utopsy findings available<br>completion of cause of |
| a                 |  |                  | 25. Was case referred to medical  |  | -   |  | 1□ Yes 2↓                             |                               |   |
| ₹                 | Physician:<br>r this certificral director,   | o Be             | examiner?  1 Yes 2 No Hospital: 1 Inpati  | ent 2 ☐ ER/Outpatie                            | Other   | <ol> <li>Place of Death (</li> <li>A□ Nursing Home</li> </ol>  |                                       | e 6 □Other (Spe               | ecify)  |
| ō                 | ding Phy<br>h.<br>After this<br>funeral c  | n: To            | 27. Manner of Death 28a. Date of Inju   | ıry 28b. Time o                                |   |  | d. Describe how                       |                               | ,   |
| io                | Attending r death. ector: After by the funer   | atio             | 2 Accident investigation  | y reary many                                   |   | 3 2 □ No   |                                       |                               |   |
| Division          | or Atta<br>ter de<br>virectu   | Certification:   | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of in building, e  | ury - At home, farm, st<br>c. <i>(Specify)</i> | reet, factory, office                             | 28   | f. Location (Stree<br>City or Town, S | at and Number or F<br>State)  | Rural Route Number,                                 |
| Ω                 | ospital or Attenct<br>hours after death<br>uneral Director:<br>ly filled in by the   |                  | 29a. Certifier 1 Certifying Physician: To the best  | of my knowledge, dea                           | th occurred at the time                           | date and place, as   | nd due to the caus                    | ea(e) and manner a            | e stated  |
|                   | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the   | Medical          | (Check only one)    Medical Examiner: On the basis one) and manner si   | of examination and/or i                        |   |  |                                       |                               |   |
|                   | ro the within Fo the comple  | Me               | 29b. Signature and title of certifier   | \  | 29c. License nu                                   | umber  | 29d.                                  | Date signed (Mor              | th, Day, Year)                                      |
|                   |  |                  | ▶ Yout !  | l'éfusse                                       | RES   | 0000   |                                       | 2/10/8                        | 3   |
|                   | 2  |                  | 30. Name and address of person who completed cause of   | leath (Item 23a) (Type                         | , Print)  |  | , a                                   |                               | 1) 2:- 27   |
|                   | J  |                  | Dr. Yout Negusse 9  | UUU FrM  | nkin squa   | WE DYI   | re Balt                               | move, 1                       | 10 21251  |
|                   | Sta<br>Registi   |                  | 31. Date filed (Month, Day, Year) 32. Rost  | ar's Signature                                 | Lank.   |  |                                       | •                             |   |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 2 **Physician** 2008 1:05 Dorothea L. Bagley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St Joseph Hospital Towson Balto If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 11-27-1960 **Funeral** 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Months Days Hours Min 1□M 3€7F 213-78-3463 Director 47 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show at notified 1 X Yes 2 □ No Director 28a-f MDN/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code must be items 23a 3017 Pulaski Highway 21224 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14 Bace - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò by t 1 ☐ Yes 21 No Specify. Black Specify: 3 Widowed 4 Divorced Year or Dates: 'natural", Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Manor Care (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home College 12th grade Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Menta item 27 is marked William Flovd June Johnson ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger Bagley, Sr -Husband 3017 Pulaski Highway Balto, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt Carmel Cemetery 2-15-08 Balto, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses March F/H East 21202 1101 E. North Avenue Balto, MD 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final andi Physician O Vascular 110 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner death certificate be executed physician and the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical as 1 ed by the attending properties of detached for use as IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) P.O. | cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼ No 24a. Was an autopsy perform certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊈Yes 2□ No 1 Inpatient 2 XER/Outpatient 3 □ DOA ပ After this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) simble. 31. Date filed (Month. Day. Year) 32 Registrar's Signature State FEB Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner //a hmore 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours 22-3760 Days 1 □ M 2 □ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-dical Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 34 21234 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: To Be Completed by Specify: WKIFE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Baltimore 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit 21222 1/104 Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician neumonia /Medical consequence of): Examiner multyre Sequentially list conditions, france, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for es a consequence of) use as the turial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? cate has been signed by the a page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4. Onknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2□ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 31 No ို 1 ☐ Yes 1 | Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 □ Yes 2 □ No investigation 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Sigpature and title of certif 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

|   |  |                | For<br>State<br>Registrar  | State of Maryla  | •                                | rtificate of   |   | nıaı mygler<br>Reg. 1                                     |                                |  |
|---|--|----------------|--|--|----------------------------------|--|---|---|--------------------------------|--|
|   | Physici  | an             | 1. Decedent's Name (First, Middle, La  | 1. Blance  | band                             |  | 2   |   | Day 2008                       | 3. Time of Death                                   |
|   | /Medio   |                | 4a. Facility Name (If not institution, give harlestown  5. Social Security Number 6.8  | e street and number)  LOVE CENT  Eex 7. Age (In yn   | ER s. last birthday)             | Cato.  | or Location of Death  WSVI // E  If Under 24 Hrs. 8  Hours Min. 8 |   | 4c. County of Deat             |  |
|   | Director   |                | 215-03-1145 Usual Residence of Decedent  | □M 2EF   | 2 Yrs.                           | Months Days  | Hours Min.  | 1-16-1  | 916                            | OH   |
| 000                                       | r 28a-f show   | Director       | 10a. State 10b. County  Balth ma   | 10c. C   | City, Town or Lo                 |  |   | 10g. (  | Citizen of What Co             | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No untry?      |
| O Charles and                             | when it is nous are bean with the maryand<br>than "natural", or items 23a or 28a-f show<br>he Medical Examiner must be notified at | Funeral        | 709 Maiden C<br>11. Marital Status<br>1 □ Never Married 2 Married  | 12. Was Decedent Ever in Armed Forces?  1   Yes 2   No If Yes, Give  |                                  | 2/2:<br>Was Decedent of H<br>If Yes, specify Cub             | lispanic Origin? (Specif<br>an, Mexican, Puerto Ric               | fy Yes or No-<br>can, etc.)                               | 14. Race - Ame<br>Black, White | rican Indian,                                      |
| Z15-0036                                  | trail Hygiene.  d other than "natural"; event, the Medical Exa   | Completed by   | 3 ☐ Widowed 4 ☑ Divorced  15. Decedent's E (Specify only highest gra  Elementary/Secondary (0-12)  | Year or Dates:   | 16a. Deced                       | dent's Usual Occup<br>kind of work done<br>DO NOT use retire | pation<br>during most of working<br>d)                            |   | Specify: Kind of Business/     |  |
|   | Hygier other the   |                | 17. Father's Name (First, Middle, Last   | )  | H                                | omemak   | 18. Mother's Name (F  |   |                                | ne   |
| ylan                                      | Mental<br>Mental<br>arked c  | To Be          |  | Fiest  |                                  |  | Emma  |   |                                |  |
| Mar                                       | alth and<br>n 27 is m  |                | 19a. Informant's Name/Relationship   | Type. Print) Ster - Durchk R   | 19b. Mailir                      | HoDe-  | and Number or Rural F   | Route Number, Cit   | nan i                          | (ip Code)  |
| <u> </u>                                  | artment of Healt<br>ortant: If Item 2<br>injury or other   |                | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐  | 1  | Place of Dispo<br>cemetery, crei | sition (Name of<br>matory or other pla                       | ce) Dat   | ө 20с.  | Location - City or             |  |
|   | artmen<br>ortant:<br>injury  |                | 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice  | i) La  | yview (                          | Semutor<br>2. Name and Addre                                 | 4 2-12 s of Facility Brace  | -08 B   | all more                       | MO   |
| מ<br>מ                                    | Depart<br>import<br>any in   | d a            | ATHALL   | <b>&gt;</b>  | H                                | me, PA   | , 2134 Wi   | HOW Sp.   |                                | 21222  |
|   | hysician<br>/Medical   |                | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | plications that caused the de one cause on each line.  a. Pour Company | nia                              | er the mode of dyi   | ng, such as cardiac or r  | respiratory arrest,                                       |                                | Approximate<br>Interval Between<br>Onset and Death |
|   | xaminer  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cuisease of injury that initiated events                    | b. Due to (or as a conse   | equence of):                     |  |   |   |                                |  |
| os/ou,                                    | incare be executed<br>ig physician and<br>as the burial-transit  | edical Exar    | that initiated events resulting in death) Last   | Due to (or as a conse  | equence of):                     |  |   |   |                                |  |
| The law requires that the death confident |  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  | 23c. If yes, outcome pf preg<br>1 ☐ Live birth 2 ☐ Fe<br>4 ☐ Pregnant at time of<br>9 ☐ Unknown  | tal death 3                      | ∃Ectopic pregnanc<br>∃ Other <i>(specify)</i> _              | у   |   | 23d. Date of del<br>Month      | ivery<br>Day Year                                  |
| Records, P.                               | en signed b  | þ              | Part II. Other significant conditions  | contributing to death but not re   | esulting in the u                | nderlying cause giv  | ven in Part I.  |   | o use contribute to            | the cause of death?                                |
|   | ate has  | Completed      | OF Was again referred to medical   |  |                                  |  |   | 24a. Was an autopsy performed                             | prior to death?                | topsy findings available completion of cause of    |
|   | nis certi  | To Be          | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No  | Hospital: 1 ☐ Inpatient 2  | ☐ ER/Outpatien                   | nt 3 DOA Oth   | 26. Place of Death (coner:  4 Nursing Home                        |   | 6 □Other (Spe                  | cify)  |
| OIVISION OI                               | r death.<br>ector: After they they they they they the funeral  | Certification: | 27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigatio 6 Could not b determined                                       | e 28e. Place of injury - At  | 28b. Time of injury              | M 1□   | rƙ?<br>]Yes 2□No  | d. Describe how in  | and Number or Ri               | ıral Route Number,                                 |
| U Hoenital or                             | within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di                           | Medical Cert   | 29a. Certifier Certifying Pl   | building, etc. (Specially sides)  | nowledge, deatl                  | h occurred at the ti<br>vestigation, in my                   | ime, date and place, an<br>opinion, death occurred                | City or Town, Stored due to the cause I at the time, date | e(s) and manner as             | s stated.<br>e to the cause(s)                     |
| Totho                                     | within<br>To the   | Me             | 29b. Signature and title of certifier  | and the state of   | <u> </u>                         | 29c. Licens  | se number   | 29d. l  | Date signed (Mont              | h, Day, Year)                                      |
| 6   | T  |                | Infunc   | completed cause of death (1)   | am 22a) (Terra                   | D3   | 0989  | Fel   | onany                          | 8005 11  |
| 3   | 1  |                | 30. Name and address of person who maiden c  | hoice Lane   | Cott                             | sosville   | S OM S  | 2551  |                                |  |
|   | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)  | 32. Flegistrar's Sig   | nature                           | mile   | s om s  |   |                                |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State amend #20c Per FH G876 2/14/Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 9,0W M **Physician** 200 % /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days **X** M 2 □ F 216-30-0837 72 Director 04/07/1935 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f sh notified a Baltimore 1 XYes 2 ☐ No Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or a Medical Examiner must be n 21215 U.S.A. 4300 Granada Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? unkown 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Black Specify: þ 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Safety Engineer Defence Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Berkley Dorothy Hooper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1235 Glen Eagle Rd., Baltimore, Maryland 21239 Health Pm 27 | permit. Pages 1 and:
Department of Health
Important: If Item 27
any Injury or other tra John Berkley / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Druid Ridge Cemetery 02/14/2008 Pikesville, Maryland Pikesville, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 176002 MERCHANNIC INFONETICW /Medical Due to (or as a consequence of) **Examiner** CONOMARE NOTERY 1 ANOMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): DS5453 Examine death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy 1☐Live birth ∠☐ retail 4☐ 4☐Pregnant at time of death in the past 12 months? Month Year Day 5 Other (specify) been signed by the s should be detached 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> +m>>282 1 ☐ Yes 2 😿 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed? Yes 2 1 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Pay Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation N(+) er death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and 2-11-08

Registrar DHMH 17 Rev 1/2001

State

Samuel Berkley

2300

a wowen

21716

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

1CFIAND

FEB 14

31. Date filed (Month, Day, Year)

HONZ

State of

32. negistrar's Signature

Registrar

Charles Car

FEB 14

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Senner **Physician** -0 /Medical 4c. County of Death 4b. City, Town, or Location of Death Expility Name (If not institution, give street and number) **Examiner** UASh ried OLER Bur If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours 1 M 2 K 12/14/42 Director 464-60-4523 65 Usual Residence of Decedent 10c. City, Town or Location death with the Maryland 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at Director Pasadena MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 by Funeral 1203 June Way Race - American Indian. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 "natural", or Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M 10 <u>Homemaker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Alpha louise Milton Blake 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1203 June Way Pasadena, Maryland 21122 F. Benner, Sr. /Husband Charles 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland 2/14/08 4 Donation 5 Dother (Specify) Loudon Park Cemetery 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Euneral Service Licer 3620 Wilkens Ave. Baltimore, Maryland 21229 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, le cause on each line. 23a. Part1. Enter the disease, or composhock, or heart fallure. List only Immediate Cause (Final teriosclero **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consection to of) Examine certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ned by the atten detached for u in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) I□Yes 2 No 9 Unknown sate has been signed by page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Proknown Completed 24a. Was an autopsy 1 2 No certificate Yes To the Hospital or Attending Physiclan: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 3□ DOA 1 Yes 2∏ No 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: within 24 hours after death.

To the Funeral Director: After Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

2008

820

Birthplace (State or Foreign Country)

White

Home

10d. Inside City Limits

1 ☐ Yes 2 No

Arkansas

USA

Black, White, etc.

29d. Date signed (Month. Day, Year)

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Name and address of person who completed

DHMH 17 Rev 1/2001

29c. License number

|                                     |  |                | For<br>State<br>Registrar  | State of Marylar   |                        |                  |                           | ealth an<br>Death          | d Mer           |                               | ene200                    | 8         | 04246                                  |
|-------------------------------------|--|----------------|--|--|------------------------|------------------|---------------------------|----------------------------|-----------------|-------------------------------|---------------------------|-----------|--|
|                                     |  |                | Decedent's Name (First, Middle, Last)  |  |                        |                  |                           |                            | 2.              | Date of Death                 |                           |           | 3. Time of Death                       |
|                                     | Physici<br>/Medio  |                | Irma Sa  | kowski   | Вос                    | ker              |                           |                            | Fe              | Month<br>bruary               | Day 200                   | ear<br>38 | 1:30 a <sup>M</sup>                    |
| i.                                  | Examin   |                | 4a. Facility Name (If not institution, give st   | reet and number)   |                        | 4b. Cit          | , Town, or                | Location of D              | _               |                               | 4c. County of             |           |  |
|                                     |  |                | Genesis Rehab  |  |                        | В                | rook1                     | yn Par                     | k               |                               | Ann                       | e A       | rundel                                 |
|                                     | Funeral  |                | 5. Social Security Number 6. Sex   | 7. Age (In yrs.  | last birthday)         | If Und<br>Month: |                           | If Under 24 I              | Hrs. 8.<br>Vin. | Date of Birth<br>(Month, Day, | Year) 9                   | . Birthp  | lece (State or Foreign                 |
|                                     | Director   |                | 220-07-1377  | M 2XIF 86  | Yrs.                   |                  | Su) S                     |                            | A               | pril 20                       | 5, 1921                   | Mar       | yland                                  |
|                                     | D .  |                | Usual Residence of Decedent  10a. State 10b. County  | 10c Ci   | ty, Town or Lo         | cation           |                           |                            |                 |                               |                           | 1         | 0d. Inside City Limits                 |
|                                     | eho<br>eho   | 7              |  |  |                        |                  |                           |                            |                 |                               |                           |           | 1 ☐ Yes 2 🛣 No                         |
|                                     | Ne N   | Director       | Maryland   Anne Arun   | del Gle  | n Burn                 |                  | ip Code                   |                            |                 | 10                            | g. Citizen of Wh          | at Cour   | utn/2                                  |
|                                     | with<br>a or   | 급              | 714 Baylor Road  |  |                        |                  | 1061                      |                            |                 | 10                            | USA                       | at 0001   |  |
|                                     | eath   | eral           |  | 2. Was Decedent Ever in U  | S 13 V                 |                  |                           | ispanic Origin'            | ? (Specify      | Yes or No-                    | 14. Race -                | Americ    | an Indian.                             |
| 336                                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "netural", or Items 23a or 28a-f ehow any Injury or other treumatic event, the Madical Extractional be notified at any futury or other treumatic event, the Madical Extractional be notified at another. | by Funeral     | 1 Never Married 2 Married 3 Widowed 4 Divorced   | Armed Forces?  1 Yes ZX No If Yes, Give Year or Dates:                           | 1                      | f Yes, sp        | ecify Cuba<br>20 No       | n, Mexican, Pi<br>Specify: | uerto Ric       | an, etc.)                     | Black, Specify:           | White,    |  |
| Ą                                   | 2 ho   | Completed      | 15. Decedent's Educa   |  | 16a. Deced             | ent's Us         | ual Occupa                | ation                      |                 | 1                             | 6b. Kind of Busin         | ness/Ind  | dustry                                 |
| 215                                 | hin 7  | pie            | (Specify only highest grade Elementary/Secondary (0-12)  | College (1-4or 5+)   | life. L                | DO NOT           | ont done d<br>use retired | during most of             | working         |                               |                           |           |  |
| 21                                  | gien arth  | ь<br>По        | 12   |  | Co                     | il M             | aker                      |                            |                 |                               | Bendi                     | x         |  |
| g                                   | a Hy<br>Oth  | Be (           | 17. Father's Name (First, Middle, Last)  |  |                        |                  |                           | 18. Mother's               | Name (F         | irst, Middle, M               | aiden Sumame)             |           |  |
| <u>a</u>                            | Ments<br>Ments<br>arked  | T0             | Adolph   | Sakowski   |                        |                  |                           | Mary                       |                 |                               | Henry                     |           |  |
| Maryland 21215-0036                 | alth and 27 is my reference  |                | 19a. Informant's Name/Relationship (Typ<br>Donna Dupuis (Niece   |  |                        | •                |                           |                            |                 |                               | City or Town, St. MD 2109 |           | Code)                                  |
| altimore,                           | of Her   | 1 8            | 20a. Method of Disposition   |  | Place of Dispo         | sition (N        | ame of<br>other plac      | e)                         | Date            | 2                             | 0c. Location - Ci         | ty or To  | wn, State                              |
| Ë                                   | Pages<br>nent of h<br>ent: If Its<br>ary or o  |                | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)  |  | don Pa:                |                  |                           |                            | 16/0            | 8 Ва                          | ltimore                   | , M       | aryland                                |
| a                                   | mit.   |                | 21. Signature of Funeral Service License   |  | 22                     | . Name           | and Addres                | s of Facility              | Loud            | on Parl                       | Funera                    | I H       | ome                                    |
| m                                   | Dapa<br>Dapa<br>Impo<br>any I  |                |  |  |                        | 3620             | Wilk                      | ens Av                     | e.,             | Baltimo                       | re, MD                    | 212       | 29                                     |
|                                     |  |                | 23a. Part I. Enter the disease, or complic<br>shock, or heart failure. List only one   | ations that caused the dea   | th. Do not ent         | er the m         | ode of dyin               | g, such as car             | rdiac or re     | spiratory arre                | st,                       |           | Approximate<br>Interval Between        |
| ,                                   | Physician  |                | Immediate Cause (Final disease or condition  | Chronic  | 200                    | ctv              | neti                      | 10                         | A.t.            | honar                         | y Dis                     | 0.00      | Onset and Death                        |
|                                     | /Medical   |                | resulting in death)  | Due to (or as a consec   |                        | 301              | acti                      | IVE                        | 1 ar            | PIDTICIT                      | 9 013-                    | 2013      | re                                     |
|                                     | Examiner   |                |  |  |                        |                  |                           |                            |                 |                               |                           |           |  |
| -                                   |  | Je             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   | Due to (or as a consec   | quence of):            |                  |                           |                            |                 |                               |                           |           |  |
|                                     | cuted<br>nd<br>ransi   | Examiner       | Cause (Disease or injury that initiated events   |  |                        |                  |                           |                            |                 |                               |                           | _         |  |
| ó                                   | an ar  | Ä              | resulting in death) Last   | Due to (or as a consec   | quence of):            |                  |                           |                            |                 |                               |                           |           |  |
| 8760,                               | icata be executed<br>physician and<br>s the burial-transit   | dicai          | d.   |  |                        |                  |                           |                            |                 |                               |                           | -         |  |
| 9                                   | ng ph<br>as t  | Med            | IF FEMALE:   |  |                        |                  |                           |                            |                 |                               |                           |           |  |
| õ                                   | th ce<br>tendi   | Physician/Me   | 23b. Was decedent pregnant   | <ul> <li>c. If yes, outcome of pregn</li> <li>1 ☐ Live birth 2 ☐ Feta</li> </ul> |                        | Ectopic          | pregnancy                 |                            |                 |                               | 23d. Date of Month        |           | Day Year                               |
| E                                   | he at  | Sici           | in the past 12 months? 1 □ Yes 2 □ No  | 4□Pregnant at time of of 9□ Unknown  | death 5□               | Other (          | specify)                  |                            |                 |                               | Wicht                     |           | Day 16ai                               |
| <u>a</u>                            | at the   | P. P.          | 9 Unknown  |  |                        |                  |                           |                            |                 | 00 0:1:-1                     |                           |           |  |
| Division of Vital Records, P.O. Box | The law requires that the death certific<br>ate has been signed by the attending is<br>page 2 should be detached for use as  | ٥              | Part II. Other significant conditions cont   | ributing to death but not res  | sulting in the u       | nderlying        | cause give                | en in Part I.              |                 |                               |                           |           | ne cause of death?<br>eably 4 ∐Unknown |
| ပ္က                                 | aw re<br>s bee   | Completed      |  |  |                        |                  |                           |                            | ĺ               | 24a. Was ar                   |                           |           | psy findings available                 |
| Ĕ                                   | The lay  | E              |  |  |                        |                  |                           |                            | _               | autopsy<br>perform<br>1 Yes 2 | ed? dea                   | th?       | mpletion of cause of                   |
| ā                                   | ician: Th<br>certificate<br>rector, pag  | 0              | 25. Was case referred to medical   |  |                        |                  |                           | 26. Place of               | Death (C        | heck only one                 |                           |           | <b>y</b> -4                            |
| >                                   | ysici<br>is ce<br>direc  | To B           | examiner?<br>1 ☐ Yes 2 ☑ No  | spital: 1   Inpatient 2  | ER/Outpatien           | ıt 3∐ [          | Oth                       | er: 4 Nursir               | ng Home         | 5 Reside                      | nce 6 □Other              | (Specif   | (y)                                    |
| 0                                   | ding Phys<br>h.<br>After this<br>funeral di  | č              | 27. Manner of Death  | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of<br>Injury |                  | 28c. Injun<br>Worl        | at                         | 28d             | . Describe ho                 | w injury occurred         |           |  |
| Ö                                   | Attending Physician: or death. ector: After this certifice by the funeral director.  | atic           | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation  | (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,  |                        | М                |                           | Yes 2 □No                  |                 |                               |                           |           |  |
| Divis                               | ospital or Attend<br>hours after death<br>unerel Director:<br>ly filled in by the  | Certification; | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At h<br>building, etc. (Speci                             |                        | eet, facto       | ory, office               |                            | 28f.            | Location (Str<br>City or Town |                           | or Rura   | al Route Number,                       |
|                                     | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page   | edicai (       | 29a. Certifier (Check only one) Cartifying Physic Cartifying Physi | cian: To the best of my knows: On the basis of examination and manner stated.    | ation and/or in        | vestigation      | n, in my o                | pinion, death o            | occurred :      | at the time, da               | te and place, and         | d due to  | the cause(s)                           |
|                                     | withir<br>To th  | Me             | 29b. Signature and title of certifier  |  |                        | 2                | 9c. License               | e number                   |                 | 29                            | d. Date signed (          | Month,    | Day, Year)                             |
|                                     | 1  |                | A. V   | m A  | an                     |                  | DE                        | 5159                       | 6               | FE                            | bruare                    | 113       | 3rd 2008                               |
|                                     | H  |                | 30. Name and address of person who con   | npleted cause of death (Ite  | m 23a) (Type,          | Print)           | od                        | Road                       | 10:             | 3, G1                         | en Burn                   | rie       | Day, Year) 3 rd 2008 MD21061           |
|                                     | Sta  | ite            | 31. Date filed (Month, Day, Year)  | 32 Registrar's Sign  | ature A                | - M              | ,,,,,                     | - Sour                     | ,               | 1                             |                           | -         | 2 - 1, -0,                             |
| ١,                                  | Registr  |                | FEB 1 4 2008   | Salar A  | S. Aller               | E ST             |                           |                            |                 |                               |                           |           |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year H. Campbell. February 10 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLEN Baltimore Washington ANNE LRUNDEL Medical Center BURNIE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1□ M 2□ X 215 09 3100 Director 103 Baltimore, Maryland February 18 1904 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a 1674 Twickenham Road 21122 USA 'natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo Specify þ Specify 3 Nidowed 4 Divorced White Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: if item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 WA Retired Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sanuel Dawson Harrison Sr Mary Agnes Six 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) important: If item 27 any injury or other tr Donald H Dwyer Sr. 1674 Twickenham Road Pasadena, Maryland 21122 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages ' 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park February 16 2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Ignature of Funeral Service License 22. Name and Address of Facility

Lassahn Funeral Home Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician #tous disease or condition resulting in death) /Medical Examiner Sequentially list conditions Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and I-transit the death certificate be executed physician ar Due to (or as a consequence of): Box 68760, Physician/Medical as attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 TYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 s certificate has perform 1□ Yes or Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 5 Pending investigation 1. Natural Injury n 24 hours after death.

The Funeral Director: Af older of the full of the ful 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only within 2 29c. License numbe 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

FEB 1 4 2008

30. Name and address of person who completed cause of death (Item 23a) (Type

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|               |  | •              | For<br>State<br>Registrar   |   | .,                        | Cei                          | rtificate of  | Death                                  |   | Reg. No.         | 008   | 04248                                     |
|---------------|--|----------------|---|---|---------------------------|------------------------------|---|--|---|------------------|---|---|
|               | v L E L  | H              | 1. Decedent's Name (First, Middle, I  | .ast)   |                           |                              |   |  | 2. Date of Dea                          | ath              | Year  | 3. Time of Death                          |
|               | Physicia<br>/Medic   | _              | E   | lise I.   |                           | Curti                        | S   |  | Februar                                 | 'y 12            | , 2008  | 6:20 P <sup>M</sup>                       |
|               | Examin   | er             | 4a. Facility Name (If not institution, g  | ive street and number)  |                           |                              | 4b. City, Town, o   | r Location of Dea                      | ath                                     |                  | ounty of Death                                    |   |
|               |  |                | 105 Kenilworth P  |   |                           |                              | Tows (  |  | S O Date of Die                         |                  | Baltimo   |   |
| £             | Funeral<br>Director  |                | 5. Social Security Number  217-30-5222  Usual Residence of Decedent   | Sex 7. Age  | 75                        | Yrs.                         | Months Days   | Hours Mir                              |   | , Year)<br>1,193 | 2 Mar   | place (State or Foreign<br>ntry)<br>yland |
|               | land land  |                | 10a. State 10b. County  |   | 10c. City                 | , Town or Lo                 | cation  |  |   |                  |   | 10d. Inside City Limits                   |
|               | Mary<br>-f sho   | tor            | Maryland Baltim   | iore  | Т                         | owson                        |   |  |   |                  |   | 1 ☐ Yes 2X No                             |
|               | r 28a<br>noti  | Directo        | 10e. Street and Number  | 101 €   |                           | J. 10 J. 1                   | 10f. Zip Code   |  |   | 10g. Citize      | en of What Cou                                    | ntry?                                     |
|               | th wit   |                | 105 Kenilworth P  | ark Drive,  | Apt.                      | 3D                           | 21204   |  |   |                  | U.S.A.  |   |
|               | r dea  | Funeral        | 11. Marital Status  | 12. Was Decedent E<br>Armed Forces?                                       |                           | 3. 13.                       | Was Decedent of H<br>If Yes, specify Cuba                     | lispanic Origin? (<br>an, Mexican, Pue | Specify Yes or No-<br>erto Rican, etc.) | . 14             | <ol> <li>Race - Ameri<br/>Black, White</li> </ol> |   |
| 5-0036        | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at | ρ              | 1 ☐ Never Married 2 ☐ Married<br>3 ☐ Widowed 4 🎇 Divorced   | 1 M Yes 2 □ N<br>If Yes, Give 19<br>Year or Dates:                        | 33-1                      | 954                          | 1 □ Yes 2X No   | Specify:                               |   | 5                | Specify: Wh                                       | ite                                       |
| <u>7</u>      | "natu  | Completed      | 15. Decedent's (Specify only highest  | Education<br>grade completed)   |                           | 16a. Dece                    | dent's Usual Occup<br>kind of work done<br>DO NOT use retired | oation<br>during most of w             | orking                                  | 16b. Kind        | d of Business/Ir                                  | ndustry                                   |
| Maryland 2121 | within<br>ene.<br>than   | dwa            | Elementary/Secondary (0-12)   | College (1-4or 5-   | +)                        |                              | Secretary   | P)                                     |   | Stee             | 1 Manuf   | acturer                                   |
| 9<br>9        | filed<br>Hygi<br>ther<br>ent, tl   | ပ္             | 17. Father's Name (First, Middle, La  | st)   | I                         |                              | icor coar y   | 18. Mother's N                         | ame (First, Middle,                     |                  |   |   |
| an            | Mental Mental arked o  | To Be          | E. S  | Stanley   | Reis                      | ler                          |   | ۲                                      | le1en                                   | May              | Joh   | nson                                      |
| ary           | should<br>and Men<br>s marke<br>umatic   | -              | 19a. Informant's Name/Relationship  |   |                           |                              | ng Address (Street  | and Number or i                        | Rural Route Numbe                       | er, City or      | Town, State, Zi                                   | p Code)                                   |
|               | Health a tem 27 is   |                | Carol A. Freligh  | n Daughter  | ı                         | 700 W                        | lhittingto  | on Drive                               | Deale                                   | , Mar            | yland 2   | 0751                                      |
| altimore,     | 50 to 1  |                | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  | -   | 20b. Pl                   | ace of Dispo<br>emetery, cre | osition (Name of matory or other place                        | ce)                                    | Date                                    |                  | ation - City or T                                 |   |
| Ĕ             | Pages<br>ment of 1<br>ant; If Ito<br>ury or o  |                | 4 Donation 5 □ Other (Spe   | cify)   | Par                       |                              | Cemetery  |  | .4-2008                                 |                  | imore   | Maryland                                  |
| Balt          | permit. Pag<br>Department<br>Important; I<br>any injury o  |                | 21. Sign, ture of Fundral Service Lie   | ensee   |                           | 22                           | 2. Name and Addre   |  | Ruck Tows                               |                  |   | Home, Inc.<br>21204                       |
|               |  |                | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List or                                    | omplications that caused  | the death                 | . Do not en                  | ter the mode of dyir  | ng, such as cardi                      | ac or respiratory as                    | rest,            |   | Approximate<br>Interval Between           |
|               | Physician  | ì              | Immediate Cause (Final disease or condition   | . 1   | 11                        | 19                           | CAN   | cer                                    |   |                  |   | Onset and Death                           |
| 8             | /Medical   |                | resulting in death)   | Due to (or as a   | consequ                   | ence of                      |   |  |   |                  |   | 7700                                      |
|               | Examiner   |                | Sequentially list conditions,   | b   |                           |                              |   |  |   |                  |   |   |
|               | sit ed   | ine            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a   | consequ                   | ence of):                    |   |  |   |                  |   |   |
| Ý             | and<br>and<br>I-tran   | Examiner       | that initiated events resulting in death) Last  | c<br>Due to (or as a  | consequ                   | ence of):                    |   |  |   |                  |   |   |
| 68760, 6      | cate be executed<br>physician and<br>the burial-transit  |                |   |   |                           | •                            |   |  |   |                  |   |   |
| 687           | ortificate be executed<br>ing physician and<br>e as the burial-transit   | Medical        |   | a   |                           |                              |   |  |   |                  |   |   |
| O. Box        | The law requires that the death certi<br>te has been signed by the attending<br>age 2 should be detached for use a   | Physician/M    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                     | 23c. If yes, outcome p<br>1 □Live birth<br>4 □ Pregnant at<br>9 □ Unknown | 2 🗌 Fetal                 | death 3                      | ⊒Ectopic pregnanc<br>∃ Other (specify) _                      | у                                      |   | 23               | 3d. Date of deliving Month                        | very<br>Day Year                          |
| P.0           | that the ed by detac   |                | Part II. Other significant condition  | s contributing to death bu  | t not resu                | lting in the u               | nderlying cause giv   | ven in Part I.                         | 23e. Did to                             | obacco us        | e contribute to                                   | the cause of death?                       |
| ds,           | uires<br>I sign  | d by           |   |   |                           |                              |   |  | 18                                      | res 2□           | No 3□Pro  | bably 4 ∐Unknown                          |
| Ö             | w req  | lete           | And a   |   |                           |                              |   |  | 24a. Was                                | an I             | 24b. Were aut                                     | opsy findings available                   |
| Records,      | he law<br>e has l  | Completed      |   |   |                           |                              |   |  | - autor<br>perfo                        | sy<br>rmed2      | prior to or<br>death?                             | ompletion of cause of                     |
| Viita         |  | a              | 25. Was case referred to medical  |   |                           |                              |   | 26. Place of D                         | 1  Yes<br>eath (Check only o            | 2≦No<br>ne)      | 1 ☐ Yes   | 2□No                                      |
| >             | ysici<br>is cer<br>direct  | To B           | examiner?<br>1 Tes 2 No   | Hospital: 1 ☐ Inpatie   | nt 2 🗆 E                  | ER/Outpatie                  | nt 3 DOA Oth  | ar.                                    | Home 5 Resid                            |                  | □Other (Spec                                      | ify)                                      |
| 0             | Attending Physician: r death. ector: After this certific. by the funeral director,   |                | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending   | 28a. Date of Injur<br>(Month, Day   |                           | 28b. Time o                  | f 28c. Inju   |  | 28d. Describe                           |                  |   |   |
| <u>S</u>      | endir<br>eath.<br>or: Al   | atic           | 2 Accident investigat   | the second  |                           |                              | M 1□  | Yes 2 □ No                             |   |                  |   |   |
| Division or   | or Attendater death  | Certification: | 3 Suicide 6 Could no<br>4 Homicide determine  | 28e. Place of inju<br>building, etc                                       | ry - At hou<br>. (Specify | me, farm, sti<br>')          | reet, factory, office   |  | 28f. Location (S<br>City or Tox         |                  | Number or Rui                                     | ral Route Number,                         |
|               | pital  |                | 29a. Certifier 1 Certifying   | Physician: To the best of   | of my know                | uledge deat                  | h occurred at the ti  | me data and pla                        | and due to the                          | 001100(0)        | and manner of                                     | stated                                    |
|               | To the Hospital or Ai<br>within 24 hours after of<br>To the Funeral Direc<br>completely filled in by   | edical         | (Check only one)  | caminer: On the basis of<br>and manner sta                                | examinat                  | ion and/or ir                | vestigation, in my  | opinion, death of                      | curred at the time,                     | date and         | place, and due                                    | to the cause(s)                           |
|               | ro the   | Me             | 29b. Signature and title of certifier   | A D   |                           |                              | 29c. Licens   |  |   |                  | signed (Month                                     |   |
|               | > 0  |                | I A hath  | - Arten   | ·                         | 0                            | 023   | 5205                                   | /                                       | Febr             | VAVY1   | 3 2008                                    |
| •             | 1041   |                | 30. Name and address of person w  | o completed cause of de   |                           | 23a) (Type,                  | Pript)  | C 1                                    | 11                                      |                  |   | 3, 2008                                   |
|               | 10 1   |                | W. A. Kiley   | 6 BMC 6   | 761                       | N.C                          | horles.   | St. Ka                                 | lfs. and                                | 20               | 20%   |   |
|               | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)  FFR 1 4 200  | 32. Registra  | ır's Signat               | ture                         | E   |  |   |                  |   |   |
|               |  |                | TLU 14 CO   | 1   | × 10                      | 5 B                          |   |  |   |                  |   |   |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

|   |                  | 1 - State Registrar   | Cer                              | tificate of Dea  | ath                                   | Re                                       | g. No.2008                                  | 042  | 49       |
|---|------------------|---|----------------------------------|--|---------------------------------------|--|---|--|----------|
|   |                  | 1. Decedent's Name (First, Middle, Last)  |                                  |  |                                       | Date of Death     Month                  |   | 3. Time of De<br>3:22 p                      |          |
| Physic<br>/Med  |                  | Gladys (  | Chatma                           |  |                                       | F  | eb 9, 2008 Year                             |  | M        |
| Exam  |                  | 4a. Facility Name (If not institution, give street and number)  |                                  | 4b. City, Town, or Loca                                  |                                       | 2050                                     | 4c. County of Dea                           | th<br><b>N/A</b>                             |          |
|   | Ţ                | 826 North Augusta Avenue  | e                                | If Under 1 Year   If U                                   | Baltin<br>Inder 24 Hrs.               | 8. Date of Birth                         | l o Bir                                     | thplace (State or F                          | Foreign  |
| Funera<br>Directo   |                  | 5. Social Security Number 6. Sex 7. Age (In yrs. 1 ☐ M 2 ▼ F 8:   | Vro                              |  | ours Min.                             | (Month, Day,<br>Jul 16,                  | rear) I C                                   | So.Carolina                                  | or eight |
| w   |                  | Usual Residence of Decedent  10a. State 10b. County 10c. Cit  | y, Town or Loc                   | cation   |                                       |  |   | 10d. Inside City                             |          |
| Aaryk<br>f sho<br>ed at   | ō                | Maryland N/A  |                                  | Baltin   | more                                  |  |   | 1 Yes 2                                      | 2□No     |
| the N<br>28a-<br>notifi   | rect             | 10e. Street and Number  |                                  | 10f. Zip Code  |                                       | 10                                       | g. Citizen of What C                        |  |          |
| 3a or   | Funeral Director | 826 North Augusta Street  |                                  |  | 21229                                 |  | U.  | S.A.   |          |
| death<br>ms 2   | nera             | 11. Marital Status 12. Was Decedent Ever in U<br>Armed Forces?  | .S. 13. V                        | Was Decedent of Hispan<br>f Yes, specify Cuban, M        | nic Origin? (Spe<br>lexican, Puerto I | cify Yes or No-<br>Rican, etc.)          | 14. Race - Am<br>Black, Wh                  |  |          |
| <b>EAITIMOYE,</b> IMARYJIANG 21213-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at | by Fu            | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:  |                                  |  | pecify:                               |  | Specify:                                    | Black  |          |
| 2 hor   | ted              | 15. Decedent's Education (Specify only highest grade completed)   | 16a. Deced                       | lent's Usual Occupation                                  | n<br>a most of workir                 | na   1                                   | 6b. Kind of Business                        | s/Industry                                   |          |
| Ban "r  | Completed        | Elementary/Secondary (0-12) College (1-4or 5+)  | life. L                          | kind of work done during<br>DO NOT use retired)<br>Homen |                                       |  | Owi   | n Home                                       |          |
| ed wi   | S                | 12  |                                  |  |                                       | (First, Middle, N                        | laiden Surname)                             |  |          |
| Viand  vuld be file  Mental Hy  arked oth   | Be               | 17. Father's Name (First, Middle, Last)  Solomon Rosemond   |                                  | 10.  | Wouler 3 Hame                         |  | Rosemond                                    |  |          |
| yle   | ြင               | 19a. Informant's Name/Relationship (Type. Print)  | 19h Mailin                       | ng Address (Street and I                                 | Number or Rura                        | ıl Route Number.                         | City or Town, State,                        | Zip Code)                                    |          |
| Mar<br>nd 2 sh<br>lith and<br>27 is m   |                  | Darlene Chatman   | 8                                | 26 North August  | ta Avenue I                           | Baltimore, N                             | laryland 21229                              | 9  |          |
| Te,   |                  | 20a. Method of Disposition 20b.   | Place of Dispo                   | sition (Name of matory or other place)                   |                                       | Date 2                                   | 20c. Location - City of                     | r Town, State                                |          |
| Pages<br>ent of   | 1                | 1 □ Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  |                                  | ng Memorial Park   | •                                     | 02/14/08                                 | Winds                                       | or Mill, Md.                                 |          |
| Saltimore, bermit. Pages 1 al Department of Hea Important: If item  | ej j             | 21. Sign Jure of Funeral Service Licentee   |                                  | 2. Name and Address of                                   | Facility                              | I Comino                                 | D A   |  |          |
| a med a   | Š                | 1 lax 1. 63 los   | , SP                             | Estep Brot   | thers Fune<br>aw Place Ba             | ral Service,<br>altimore, Mo             | 21217                                       |  |          |
|   |                  | 23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.  | th. Do not ent                   | er the mode of dying, su                                 | uch as cardiac o                      | or respiratory arre                      | est,  | Approximate<br>Interval Betw<br>Onset and De | een      |
| Physicia  | n                | Immediate Cause (Final disease or condition   | ncren                            | + to (   | cancel                                | -  |   | )  |          |
| /Medica<br>Examine  |                  | resulting in death)  Due to (or as 1 consection)  |                                  |  |                                       |  |   |  |          |
| Examine   |                  | Sequentially list conditions, if any leading to immediate Due to (or as a consecutive conditions).  | quence of).                      |  |                                       |  |   |  |          |
| led lisit   | nine             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.  | 940.100 017.                     |  |                                       |  |   |  |          |
| xecul<br>and  | Examiner         | that initiated events c Due to (or as a consecuting in death) Last Due to (or as a consecutive for the consecution of the consecutio              | quence of):                      |  |                                       |  |   |  |          |
| 68760, fificate be ex physician as the burial   |                  |   |                                  |  |                                       |  |   |  |          |
| 68760, rifficate be executed g physician and as the burial-transit  | Aedical          |   |                                  |  |                                       |  |   |  |          |
| ox<br>h cert<br>endin   | N/M              | IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fel  |                                  | ∃Ectopicpregnancy  |                                       |  | 23d. Date of o                              |  | ear      |
| death cer<br>death cer<br>e attendir  | sicia            | in the past 12 months?  1 ☐ Yes 2 ☐ No  9 ☐ Unknown   |                                  | Other (specify)  |                                       |  | WOTH  | Day  | Cui      |
| I Records, P.O. Box  The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use  | Physician/       | 9 ☐ Unknown  Part II. Other significant conditions contributing to death but not re   | sulting in the u                 | indorlying cause given in                                | n Part I                              | 23e Did to                               | pacco use contribute                        | to the cause of de                           | eath?    |
| S, res the rigned be de   | 2                | , later and a significant and | sulling in the u                 | inderlying cause given in                                | ii i aiti.                            | 1 □ Ye                                   |   | Probably 400                                 | _        |
| Orc<br>requi  | ted              | 1   |                                  |  |                                       | 04- 144                                  |   | autopsy findings a                           |          |
| Records, The law requires the has been signed age 2 should be or  | Completed        | ·   |                                  |  |                                       | 24a. Was a<br>autops<br>perfori          | y prior t<br>med2 death                     | o completion of ca<br>?                      | use of   |
| al F  |                  |   |                                  |  | . Di                                  | 1☐ Yes                                   | No 1□Y                                      | es 2□No                                      |          |
| Vital sician: T certificat rector, pa   | B                |   | ☐ ER/Outpatie                    | Othor  | 4 Nursing Ho                          | h (Check only on                         | ence 6 ⊡Other (S                            | necify)                                      |          |
| OF<br>Physical dispersion of  | 2                | 27 Managed Death 200 Date of Injury   | 28b. Time o                      |  |                                       |  | ow injury occurred                          |  |          |
| on<br>ding<br>th.<br>: Afte   | į                | 1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation  | Injury                           |  | 3 2 □ No                              |  |   |  |          |
| Division or lor Attending Physafter death. Director: After this lin by the funeral di   | ifica            | 3 Suicide 6 Could not be determined 28e. Place of injury - At building, etc. (Spec  | home, farm, st                   | reet, factory, office                                    |                                       | 28f. Location (Si                        | treet and Number or<br>n, State)            | Rural Route Numi                             | ber,     |
| Eal or safte  | Certification:   | January, Sto. (Spec   |                                  |  |                                       |  |   |  |          |
| Division or Vital Rec<br>To the Hospital or Attending Physician: The law<br>within 24 hours after death.  To the Funeral Director: After this certificate has<br>completely filled in by the funeral director, page 2   | Medical          |   | nowledge, dea<br>nation and/or i | th occurred at the time, nvestigation, in my opini       | date and place,<br>ion, death occur   | and due to the or<br>rred at the time, o | ause(s) and manner<br>late and place, and o | as stated.<br>lue to the cause(s             | )        |
| <b>Го the</b><br>vithin<br>Г <b>о the</b><br>хотры  | Me               | 29b. Signature and title of certifier   |                                  | 29c. License nu  |                                       |  | 9d. Date signed (Mo                         | onth, Day, Year)                             |          |
| ->-0  |                  | DAN K   |                                  | _ D ~  | 1085                                  | 1  | 2 111                                       | 12008  |          |
| 1   |                  | 30. Name and address of person who impleted cause of death (Ite   | em 23a) (Type                    | , Print)<br>27 S+ P.                                     | n 1                                   | Balti                                    | nor 21                                      | 202  |          |
|   | State            | Of Date Stad (Month Day York) 32 Reflictrar's Sign  | nature                           | 27 St P.   |                                       |  |   |  |          |
| Regi  | istra            | FEB 1 4 2008 Mene   | 15. 19                           | 1942 J   |                                       |  |   |  |          |

| Physician    Account Name (First, Medical, and Day 1980)   Account N | 08-01140<br>Reuben Croslar   | nd. Ji         | Please Type or Print in Black Inde   |  | lana  |
|--|--|----------------|--|--|---|
| Physician   Control of Deep    |  | ,              | 1- For State Certific  |  | 6740 0007   |
| Reuben Crosland, Jr.   February 9, 2008   February 9, 2008   St. Fastly Start (Inclinibilities, up we street and number   St. Agnes Hospital   St. Fastly Start (Inclinibilities, up we street and number   St. Agnes Hospital   St. Fastly Start (Inclinibilities, up we street and number   St. Agnes Hospital   St. Fastly Start (Inclinibilities, up we street and number   St. Agnes Hospital   St. Fastly Start (Inclinibilities, up we street and number   St. Agnes Hospital   St. Fastly Start (Inclinibilities, up we street and number   St. Agnes Hospital   St. Fastly Start (Inclinibilities, up we street and number   St. Agnes Hospital   St. Fastly St. |  | an/            | Decedent's Name (First, Middle,Last)   |  | 2. Date of Death  Month  North  North  North  North   |
| St. Agnes Hospital  St. Social Security Number  10   | Medical Exam   |                | Reuben Crostana, Jr.   |  | February 9, 2008  |
| Social Security Number   Social Security Num   | N.   |                |  |  |   |
| 214-80-6087   12   | Euporali   |                |  |  |   |
| Description of the property    |  |                |  | Months Days Hours Min  | Foreign   |
| Mid. N/A Baltimore    10, 2g Case   10g Citer of Wheat Country?  |  |                |  | 113.   | 6/21/1900   Md.   |
| Physician (Medical xaminer)  23a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, sho | v any  |                | 10a. State 10b. County 10c, City, Town   | n or Location  |   |
| Physician (Medical xaminer)  23a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, sho | land<br>f shov   | ō              |  |  |   |
| Physician (Medical xaminer)  23a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, sho | Mary r 28a-  | rect           | 10e. Street and Number   | 10f. Zip Code  | 10g. Citizen of What Country?   |
| Physician (Medical xaminer)  23a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, sho | th the   | <u>D</u>       |  |  |   |
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| Physician (Medical xaminer)  23a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, sho | ours a<br>atura  | d b            | 15. Decedent's Education (Specify only highest grade completed) 16a  |  | work done 16b. Kind of Business/Industry  |
| Physician (Medical xaminer)  23a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, sho | 6<br>n 72 h<br>an "n<br>ical E   | je             |  |  | ,   |
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| Physician (Medical xaminer)  23a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, sho | 212<br>ould bo<br>Ment<br>mark   | 흔              |  | 9b. Mailing Address (Street and Number or  | Rural Route Number, City or Town, State, Zip Code)  |
| Physician (Medical xaminer)  23a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, sho | MD<br>12 sho<br>th and<br>th and<br>umat   |                |  |  |   |
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| Physician (Medical xaminer)  23a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, sho | imo<br>Page<br>ment o<br>tant:<br>or oth   |                | 4 Danation 5 Other Speaff) King  |  | 15/2008 Windsor Mill, Md.   |
| Physician (Medical xaminer)  23a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  25a. Part I. Enter the disease, ber Confilications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or heart shock or dying, such as cardiac or respiratory arrest, shock, or heart shock or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, sho | Salt<br>ermit.<br>Depart<br>mport<br>njury   |                | 21 Sign ture of Fune   Service Lice  | 22. Name and Address of Facility Estep Brothers  | Funeral Service, P.A.   |
| failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease calling in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease calling in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease calling in death) Last  Due to (or as a consequence of):  Due to (or as a conse |  | 2 0            | 23a. Part I. Enter the disease, er complications that caused he death. Do  | ot enter the mode of dying, such as cardiac  | ce, Baltimore, Må, 21217 prespiratory arrest, shock, or heart Approximate Interval                            |
| or condition resulting in dealth)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying, cause (Deep Language)  The property of the property o | /Medical   | 8 3            | fallure. List only one cause on each line.   |  | Between Onset and   |
| The contraction of the contrac   | xaminer  |                | 404 101 1 1 101  | MI .   |   |
| Windships of the past of the p |  | L              |  |  |   |
| Windships of the past of the p |  | lie            | cause. Enter Underlying Cause  |  |   |
| Windships of the past of the p | Zi zz  | xar            |  |  |   |
| FEMALE:   23d. Date of delivery   23d. Date of Date    | xecute   |                |  | - 074 0/00/00  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No   No   24b. Were autopsy findings available prior to completion of cause of death?   1   Yes 2   No   No   25b. Was case referred to medical examiner?   1   Yes 2   No   No   No   1   Yes 2   No   No   No   No   No   No   No  | 50,<br>te be a<br>nysicia  | ledi           | #250,27,250 1, per   |  | 23d Date of delivery  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No   No   24b. Were autopsy findings available prior to completion of cause of death?   1   Yes 2   No   No   25b. Was case referred to medical examiner?   1   Yes 2   No   No   No   1   Yes 2   No   No   No   No   No   No   No  | 687<br>ertifica<br>ding p  | an/l           | 23b. Was decedent pregnant in the past 12 months?  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No   No   24b. Were autopsy findings available prior to completion of cause of death?   1   Yes 2   No   No   25b. Was case referred to medical examiner?   1   Yes 2   No   No   No   1   Yes 2   No   No   No   No   No   No   No  | OX<br>eath c   | 10             | 1 Ves 2 Ne 0 Italianim   | 5 Other (Specify)  |   |
| 25. Was case referred to medical examiner?  1 Ves 2 No  25. Was case referred to medical examiner?  1 Ves 2 No  26. Place of Death (Check only one)  27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28b. Time of Injury  28c. Injury at Work?  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Describe how injury occurred  28d. Describe how | O. B. It the d by the ached  |                |  | ng in the underlying cause given in Part I.  | 23e. Did tobacco use contribute to the cause of death?  |
| 25. Was case referred to medical examiner?  1 Ves 2 No  25. Was case referred to medical examiner?  1 Ves 2 No  26. Place of Death (Check only one)  27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28b. Time of Injury  28c. Injury at Work?  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Describe how injury occurred  28d. Describe how | , P.(<br>res tha<br>signed<br>be det   | d by           |  |  | 1 Yes 2 No 3 Probably 4 Unknown   |
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| So the standard of the standar | AR R   | ادہ ا          | 25. Was case referred to medical   | 26.Place of Death (Check   |   |
| So the standard of the standar | Vit.<br>hysici<br>this c   | ಿ              | 1 Yes 2 No Prospital 1 Inpatient 2 Y ER/   | Sulputoni S Dort   | •   |
| Solution of the production of  | T  |                |  | . Time of Injury 28c. Injury at Work?  | 28d. Describe how injury occurred   |
| So the second state and Northern Science of A Could not be determined (Specify) other scene (Check only 1 Check only 1 Che | n of<br>ding Pl<br>After<br>funera   |                | Natural 5 Dending  | 1 Von 2 Tr Nin   | 1   |
| The second secon | Sion of<br>Attending Pl<br>r death.<br>rector: After<br>by the funera                      | cation:        | Pending   FNd 2/9/2008   Fnd   Pending   PNd 2/9/2008   Fnd   PNd 2/9/2008   PNd  | u 3:30 am j  |   |
|  | Division of ital or Attending Plura sher death.  "al Director: After led in by the funera  | cation:        | Natural  Pending Investigation  Accident  Pending Investigation  Suicide  Accident  Suicide  Accident  Acc | farm, street, factory, office building, etc.   | 28f. Location (Street and Number or Rural Route Number, City  |
| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  We dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  One)  200 Signature and title of optifier  | Divisior Hospital or Attend 24 hours after death Funeral Director: tely filled in by the 1 | Certification: | Pending Investigation   Suicide   Accident   Suicide   Accident   Suicide   Accident   Accident   Suicide   Accident   Accident   Suicide   Accident   Accident   Accident   Suicide   Accident   Accident   Suicide   Accident   Accident   Suicide   Accident   Accident   Accident   Suicide   Accident   Acciden | farm, street, factory, office building, etc.  CENE eath occurred at the time, date and place, an | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4722 Vancouver St. Baltimore, MD |

O thy

State Registrar 31. Date filed (Month, Day, Year)
Registrar

DHMH 17 Rev 1/2001
OCME 2006

ODIAL

Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

O.C.M.E.

February 9, 2008

CUME

|  |   |                | For<br>State<br>Registrar   | State of  | Marylan  |                     | epartment of H<br>Certificate of I   |   | ,   | giene<br>Reg. No.                | 08                               | 04251   |  |
|--|---|----------------|---|---|--|---------------------|--|---|---|----------------------------------|----------------------------------|---|--|
|  | Physicia<br>/Medic  |                | 1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  O  Year  V  S  A  M  M  M  M  M  M  M  M  M  M  M  M  |   |  |                     |  |   |   |                                  |                                  |   |  |
|  | Examin  |                | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c.   |   |  |                     |  |   | 4c. County  | c. County of Death               |                                  |   |  |
|  | Funeral<br>Director   |                | $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$  |   |  |                     |  | h<br>/, Yea <i>r</i> )                                      | 9. Birthol<br>Count<br>Kore   | llace (State or Foreign<br>htry) |                                  |   |  |
|  | land<br>bw  |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location   |   |  |                     |  |   |   | 10                               | 0d. Inside City Limits           |   |  |
|  | Mary<br>a-f she<br>ified a  | ctor           | Maryland Anne Arundel Se  |   |  | evern               |  |   |   |                                  | 1 □ Yes 21X                      |   |  |
| 0  | ith the   | Director       | 10e. Street and Number  |   |  |                     | 10f. Zip Code  |   |   | 10g. Citizen of                  | What Coun                        | itry?   |  |
| hang   | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at            | Funeral        | 1893 Alderbey 11. Marital Status 1 □ Never Married 2 [X]  | 12. Was Deced   | es?<br>: <b>⊡v</b> No                              | .S.                 | 21144  13. Was Decedent of H If Yes, specify Cuba                            | lispanic Origin? (Spec<br>an, Mexican, Puerto R<br>Specify: | Ify Yes or No-<br>ican, etc.)   | Bla                              | ce - America<br>ack, White, e    |   |  |
| 0036   | hours after<br>tural", or ite<br>al Examine   | d by           | 3 ☐ Widowed 4 ☐ Divor   | rced Year or Date   | es:  | 10- 1               | -  |   |   | Specification 16b. Kind of B     | AS                               | sian  |  |
| <u>1</u>   | in 72 h<br>n "nati<br>fedica  | Completed      | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of work done |   |  |                     | during most of working<br>d)   |   |   |                                  | lusuy                            |   |  |
| 212  | ed within 'giene. er than '' the Mec  | Com            | Elementary/Secondary (0-1   | 12) College (1-4  | HOT 5+)  | Own                 | er/ Operato  |   |   | Janito                           |                                  |   |  |
| ) a  | be filed<br>ntal Hygi<br>ed other<br>event, t   | Be             | 17. Father's Name (First, Middle, Last)   |   |  |                     |  |   | ne (First, Middle, Maiden Surname)  |                                  |                                  |   |  |
| $\mathcal{C}$ $\mathcal{L}$ $\mathcal{A}$ Maryland   | should<br>ind Men<br>s marke<br>umatic  | 1º             |   | Yip Arm Chang 9a. Informant's Name/Relationship (Type. Print) |  |                     | Sung Joo Park  19b. Mailing Address (Street and Number or Rural Route Number |   |   |                                  | ; City or Town, State, Zip Code) |   |  |
| ₹  | and 2 s<br>ealth ar<br>n 27 is<br>er trau   |                | Paul S. Chang   |   |  |                     | 5 Norcross   |   | m, Mar  | yland 2                          | 21144                            |   |  |
| ore,   |   |                | 20a. Method of Disposition 1 X Burial 2 □ Cremati   | ion 3 □Removal from St  | 20b. F   | Place of<br>cemeter | Disposition (Name of<br>y, crematory or other place                          | ce) Da  | ite   | 20c. Location                    | - City or To                     | wn, State                                     |  |
| altimore,  | permit. Page<br>Department of<br>Important: If<br>any Injury or<br>once.  |                | 4 Donation 5 Dothe  | er (Specify)  |  | bwri                | dope Memorial I  |   | 3,2008  | Elkride                          | ge, Ma                           | aryland                                       |  |
| Bal  | permit. Departr Imports any Inji  |                | 21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Gary L. Kaufman Funeral Home at MMP, INC.  7250 Washington Blvd., Elkridge, Maryland 21075   |   |  |                     |  |   |   |                                  |                                  |   |  |
|  |   |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death  |   |  |                     |  |   |   |                                  |                                  |   |  |
|  | Physician /Medical  |                | Immediate Cause (Final disease or condition a. Eucophalopathy   |   |  |                     |  |   |   |                                  |                                  |   |  |
|  | Examiner  |                | Covonery Artery Disease   |   |  |                     |  |   |   |                                  |                                  |   |  |
|  | g #   | iner           | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (o   | quence of):  |                     |  |   |   |                                  |                                  |   |  |
| A  | ecuter<br>and<br>I-trans  | Examin         | Cause (Disease or injury that initiated events resulting in death) Last   | C   | r as a conseq                                      | luence o            | of):   |   |   |                                  |                                  |   |  |
| 68760,   | ificate be executed<br>g physician and<br>as the burial-transit   | edical E       |   | d   |  |                     |  |   |   |                                  |                                  |   |  |
| _  | rtificat<br>ng phy<br>s as th   | Medi           | IE EEMALE:  | -   | - 17   |                     |  | -   |   |                                  |                                  |   |  |
| P.O. Box   | Attending Physician: The law requires that the death certificate be executed rdeath.  Getor: After this certificate has been signed by the aftending physician and by the funeral director, page 2 should be detached for use as the burial-transit | Physician/M    | IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  4 □ Pregnant at time of death 5 □ Other (specify)   |   |  |                     |  |   | 23d. Date of delivery<br>Month Day Year   |                                  |                                  |   |  |
| rds, P   |   | þ              |   |   |  |                     |  |   | id tobacco use contribute to the cause of death?<br>☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown |                                  |                                  |   |  |
| Division or Vital Records,   |   | Completed      |   |   | ·  |                     |  |   | 24a. Was<br>auto<br>perfo<br>1□ Yes   | psy<br>prmed?                    | prior to cor<br>death?           | opsy findings available ompletion of cause of |  |
| The second secon |   |                |   |   |  |                     |  |   | 26. Place of Death Check onlone   |                                  |                                  |   |  |
| or   | Physic<br>rthis c   | 은              | 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Outler: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)   |   |  |                     |  |   |   |                                  |                                  |   |  |
| 27. Mann of Death 28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?  1 Unatural 5 Pending 22 Accident investigation  |   |                |   |   |  |                     | rk?<br>]Yes 2∐No   | □No   |   |                                  |                                  |   |  |
| Divis  | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu  | Certification: | 3 Suicide 6 □ Co  | ould not be etermined 28e. Place of building                  | of injury - At h<br>g, etc. <i>(Sp</i> ec <i>i</i> | ome, fai            | rm, street, factory, office  | 2   | 8f. Location (<br>City or To  | Street and Num<br>wn, State)     | ber or Rura                      | al Route Number,                              |  |
|  |   | Medical C      | 29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |                     |  |   |   |                                  |                                  |   |  |
|  |   | M              | 29b. Signature and title of ce  | ertifier E. Wi  | ilis   | M                   | MD, 04   | se number   |   | 29d. Date sign                   | ed (Month,                       | Day, Year)<br>0,2008                          |  |
|  | ×   |                | 296. Signature and title of certifier  Review E. Will III. D41365  February 10, 2008  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kuspital Drive, GenBurnie, MD. 21061  31. Date filed (Month, Day, Year)  32. Hagistrar's Signature.  |   |  |                     |  |   |   |                                  |                                  |   |  |
|  | Sta<br>Regist   |                | 31. Date filed (Month, Day,   | 1 4 2008 32. F  | gistrar's Sign                                     | ature               | Apadi  |   | Ì   |                                  |                                  |   |  |

|   |  |   | 1 - State of Maryland / State of Maryland /  | Department of F<br>Certificate of  |   |  | ene 0 0 8   | 04252  |  |  |  |
|---|--|---|--|--|---|--|---|--|--|--|--|
| 1   | Physici<br>/Medio  |   | Decedent's Name (First, Middle, Last)  BARBARA  ANN  |  | COHEN Feb   |  | Day 2008  | 3. Time of Death Am O6:51 Mm                       |  |  |  |
|   | Examin   |   |  | nove Baltil  |   | ity  | 4c. County of Death                               | ′A   |  |  |  |
|   | Funeral<br>Director  |   | 5. Social Security Number  217-48-6699  Usual Residence of Decedent  | Yrs. If Under 1 Year Months Days   | If Under 24 Hrs. Hours Min.   | 8. Date of Birth<br>(Month, Day,<br>03/05/1                                  | Year) 9. Birth<br>Cou                             | place (State or Foreign<br>intry)<br>MD            |  |  |  |
| Baltimore, Maryland 21215-0036  | Maryland   | To Be Completed by Funeral Director     | 10a. State 10b. County 10c. City, To   | DWN OF LOCATION  |   |  |   | 10d. Inside City Limits 1 ☐ Yes 2 No               |  |  |  |
|   | h with the   |   | 10e. Street and Number 7938 STEVENSON ROAD   | 10f. Zip Code  | T   |  |   | 10g. Citizen of What Country?  USA                 |  |  |  |
|   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic svent, it a Medical Examinat must be notified at once. |   | 11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:                               | 13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No  | lispanic Origin? (Spe<br>an, Mexican, Puerto F<br>Specify:          | cify Yes or No-<br>Rican, etc.)  | 14. Race - Ameri<br>Black, White,<br>Specify: WHI | ican Indian,<br>, etc.                             |  |  |  |
|   | d within 72 ho<br>piene.<br>r than "natur<br>the Madical   |   | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+) 4   | Sa. Decedent's Usual Occup<br>(Give kind of work done<br>life. DO NOT use retired  | during most of workir   | ng 1   | 6b. Kind of Business/Ir                           | LIQUORS  |  |  |  |
|   | uld be filed<br>Aental Hyg<br>rked othe<br>tic svent,  |   | 17. Father's Name (First, Middle, Last)  JACK  | BARTH  | 18. Mother's Name<br>RUTH   | (First, Middle, M.   | laiden Sumame)                                    | INDNER   |  |  |  |
|   | and 2 should list and No. 27 is mailer and South   |   | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  7938 STEVENSON ROAD, BALTIMORE, MD 21208          |  |   |  |   |  |  |  |  |
|   | Pages 1 ament of He<br>ant: If item<br>iury or other   |   | 20a. Method of Disposition  1 Disposition  20b. Place  | of Disposition (Name of<br>teny, crematory or other place<br>EB SHAL OM<br>VORIAL PARK   | D D D D D D D D D D D D D D D D D D D                               | /2008  | Oc. Location - City or T                          | BOXOGS JOYNIN                                      |  |  |  |
| Ball  | permit<br>Depart<br>Import<br>any In   |   | 21. Signature of Funeral Service Licensee  22. Name and Address of Facility SOL LEVINSON & BROS., INC.  8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208  |  |   |  |   |  |  |  |  |
| of Vital Records, P.O. Box 68760, hysician: The law requires that the death certificate he executed | Physician  | edical Certification; To Be Completed b | 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a                | o not enter the mode of dying wal Ha   | g, such as cardiac of   | r respiratory arres<br>NGLC  | st,   | Approximate<br>Interval Between<br>Onset and Death |  |  |  |
|   | Medical pe executed Examiner and buysician and as the burial-transit   |   | Due to (or as a consequence  | ce of): LSiO W  See of):   | 4507  |  |   |  |  |  |  |
|   | es that the death certif<br>igned by the attending<br>be detached for use a  |   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown |  | ,   |  | 23d. Date of delivery<br>Month Day Year           |  |  |  |  |
|   | w requires that I<br>been signed by<br>should be deta  |   | Part II. Other significant conditions contributing to death but not resulting Hypertension.  | en in Part I.  |   | tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown |   |  |  |  |  |
|   | iician: The law r<br>ceriilicate has be<br>rector, page 2 sh   |   | 1  |  |   | 24a. Was an<br>autopsy<br>perform<br>1 \( \text{Yes} \) 2                    | prior to co                                       | opsy findings available ompletion of cause of      |  |  |  |
|   | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page   |   |  | 28a. Date of Injury (Month, Day Year)  28b. Time of Injury Norse  28c. Injury at Work?  28d. Describe how injury occurred  28d. Describe how injury occurred |   |  |   |  |  |  |  |
|   | To the Hospital or Attending F within 24 hours after death.  To the Funeral Director: After completely filled in by the funer.   |   | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)   | farm, street, factory, office  | reet, factory, office 28f. Location (Str. City or Town,             |  |   |  |  |  |  |
|   | the Hosp<br>in 24 hou<br>the Funel<br>ipletely fil.  |   |  |  |   |  |   |  |  |  |  |
| ì   | To To Coor   | ×                                       | 29b. Signature and title of certifier  The Current - MD  |  | 29c. License number  RES - 00 0  Print)  SINAI HOSPITAL OF BALTIMON |  |   |  |  |  |  |
| 10  | •  |   | 30. Name and address of person who completed cause of death (Item 23a  | (Type, Print)  | 1 HOSPI   | TAL  | OF BA   | MINORE   |  |  |  |
|   | Sta<br>Registr   |   | 31. Date filed (Month, Day, Year) FEB 1 A 2008 32. Registrar's Signature   | Sparke   |   |  |   |  |  |  |  |

08-01162 Anne Diegel

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 04253

|  |                | - For State   | (   | Certificate d                           | of Death                        | 1                        |                               |                                   | Reg. N             | 0.                 |                                   |
|--|----------------|---|---|---|---------------------------------|--------------------------|-------------------------------|-----------------------------------|--------------------|--------------------|-----------------------------------|
| Physicia   | ın/            | I. Decedent's Name (First, Middle,Las                           | t)  |   | _                               |                          |                               | Mont                              | of Death<br>h Da   | y Year             | 3. Time of Death<br>0650 hrs      |
| ledical Exami  |                | Annie E. Diege  |   |   |                                 |                          |                               |                                   | uary 9, 2          | 4c. County of De   |                                   |
|  |                | a. Facility Name (if not institution, giv                       | e street and number)                                    |   | 4b. City, To<br>Rosed           |                          | ocation of D                  | Death                             |                    | Baltimore C        |                                   |
|  |                | Franklin Square Hospital  |   |   |                                 |                          | Ligurates                     | Alles Is Det                      | o of Dieth/A       |                    | Birthplace (State or              |
| Funeral  | 1              | 5. Social Security Number 6. Se                                 |   | yrs. last birthday)                     | If Under                        | Days                     | If Under 2<br>Hours           | Min.                              |                    | Fo                 | reign                             |
| Director   | - {            | 217 40 1147 1   | M 2 X F 90  | Υ                                       | rs.                             |                          |                               | Mar                               | ch 15              | 1917               | Country) Maryland                 |
| *  |                | Usual Residence of Decedent                                     | 1100  | City, Town or Loc                       | estion                          |                          |                               |                                   |                    |                    | 10d. Inside City Limits           |
| w any  | - 1            | 10a. State 10b. County  |   |   |                                 |                          |                               |                                   |                    |                    | 1 Yes 2 No                        |
| Aaryland<br>28a-f show<br>1 at once.   | 힐              | Maryland Baltimore  | D   | altimore C                              | 10f. Zip                        | Codo                     |                               |                                   | 100                | Citizen of What (  | Λ                                 |
| ne Mary<br>or 28a  | Director       | 10e. Street and Number  | /212  |   |                                 |                          |                               |                                   | ,                  |                    |                                   |
| 72 hours after death with the Maryland<br>n "natural", or items 23a or 28a-f sho<br>al Examiner must be notified at once   |                | 8800 Walther Blvd. Ap   | 12. Was Decedent Ever                                   | :-11 C [12.1                            |                                 | 234                      | anic Origin                   | ? (Specify Ye                     |                    | JSA<br>14 Race - A | merican Indian, Black,            |
| ıth wi<br>tems<br>st be  | uneral         | 11. Marital Status  1 Never Married 2 Married                   | Armed Forces?   | l l                                     |                                 |                          |                               | uerto Rican,                      |                    | White, et          |                                   |
| er des   | 교              |   | 1 Yes 2 X   | No 1                                    | Yes 2                           | X No                     | specify:                      |                                   |                    | Specify:           | White                             |
| rs aft<br>uraf'  | 9              | 15. Decedent's Education (Specify of                            | or Dates:   |   | lent's Usual (                  | O ccupati                | on (Give kin                  | nd of work dor                    | ie 16              | b. Kind of Busin   |                                   |
| 2 hou  | 좙              | Elementary/Secondary (0-12)                                     | College (1-4 or 5+)                                     | during                                  | most of worl                    | king life.               | DO NOT us                     | se retired)                       |                    |                    |                                   |
| 5-0036<br>led within 72 hours at<br>Hygiene.<br>other than "natural<br>the Medical Examin  | ompleted       | 10  | ŊΆ  | Farme                                   | r                               |                          |                               |                                   |                    | Self Emplo         | oyed                              |
| ed wii   | 향              | 17. Father's Name (First, Middle, Last                          | )   | \                                       |                                 | 1                        | 8.Mother's                    | Name (First, I                    | Middle, Maid       | den Surname)       |                                   |
| 21215-0036<br>hould be filed within 72 hours after<br>ad Mental Hygiene.<br>is marked other than "natural",<br>rite event, the Medical Examiner  | Be             | John Walter Richards  | son   |   |                                 |                          | Eliza V                       | Vincent_                          |                    |                    |                                   |
| ould de Me is mai  | P              | 19a. Informant's Name/Relationship (                            | Гуре, Print )   |   |                                 |                          |                               |                                   |                    |                    | State, Zip Code)                  |
| MD d 2 shot lith and in 27 is aumatic  |                | Jane Carol Vingsen  |   |   |                                 |                          |                               | ngsville<br>Date                  | . Mary             | land 2108          | ty or Town, State                 |
| re, ML<br>s 1 and 2 sl<br>of Health au<br>If item 27   |                | 20a. Method of Disposition  1 X Burial 2 Cremation 3            |   | 20b. Place of Disp<br>crematory or      |                                 |                          | netery,                       | Date                              |                    | oc. Location - O   | ty or rown, state                 |
| Page<br>Pages<br>ent o   | Ш              | 4 Donation 5 Other Specifi                                      |   | Most Holy                               | Redeem                          | er Ce                    | m. Fel                        | bruary 1                          | <u>2 2008</u>      | Baltimore          | e.Marvland                        |
| Baltimore, MD 2<br>permit. Pages I and 2 shou<br>Department of Health and<br>Important: If item 27 is r<br>injury or other traumatic   | l t            | 27. Signature of Funeral Service line                           | nsee  |   | 2. Name and<br>Lassahn          |                          |                               | <b>~</b>                          |                    |                    |                                   |
| ធ ខ្មី 🖺   |                | 23a. Part I. Enter the disease, or com                          | 20hr  | 11                                      | 7401 Pa                         | lair                     | Pood P                        | altimore                          | Morv               | land 2123          | Approximate Interval              |
| Physician  |                | failure. List only one cause on e                               | ach line.   |   |                                 |                          |                               | Olac or reality                   | stor, amesit       | air, un, in noone  | Between Onset and Death           |
| 'Medical<br>caminer  | 0, 0           |   | Complications of Ir                                     |   | ight Femo                       | oral He                  | rnia                          |                                   |                    |                    | - Beauti                          |
|  |                | or condition resulting in death)                                | Due to (or as a conseque                                | ince ot):                               |                                 |                          |                               |                                   |                    |                    |                                   |
|  | ē              | Sequentially list conditions, if any, leading to immediate      | Due to (or as a conseque                                | nce of):                                |                                 |                          |                               |                                   |                    |                    |                                   |
|  | 盲              | cause. Enter Underlying Cause (Disease or injury that initiated |   |   |                                 |                          |                               |                                   |                    |                    |                                   |
| ed<br>nsit   | Examiner       | events resulting in death) Last                                 | Due to (or as a conseque                                | ence or).                               |                                 |                          |                               |                                   |                    |                    |                                   |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after dear. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit | g              | UNPENDED  | AMENDED   |   |                                 |                          | •                             |                                   |                    |                    |                                   |
| 760,<br>icate be ex<br>physician<br>the burial   | Medical        | IF FEMALE:  | 23c. If yes, outcome of                                 | f pregnancy                             |                                 |                          |                               |                                   |                    | 23d. Date of de    | elivery                           |
| 876<br>tificate<br>ng phy<br>as the  |                | 23b. Was decedent pregnant in the past 12 months?               | 1 Live birth  | 2                                       | Fetal death                     | 3                        | Ectopic                       | pregnancy                         |                    | Month              | Day Year                          |
| Box 687 e death certifi the attending ed for use as t  | sician         | 1 Yes 2 No 9 Unknow   | 4 Pregnant at time                                      | of death 5                              | Other (Spe                      | ecify)                   |                               |                                   |                    |                    |                                   |
| Bc Bc he dear the a  | Phys           | Part II. Other significant conditions                           | 9 OHNHOWH   | t not reculting in t                    | be underlying                   | 0 021150                 | iven in Par                   | 11 2                              | 3e. Did toba       | cco use contribu   | ute to the cause of death?        |
| b.O.<br>that th  | by F           | Hypertensive Atherosole   |   |   |                                 |                          |                               |                                   |                    |                    | Probably 4 Unknown                |
| S, F<br>puires<br>an sign<br>iid be  | Completed by   |   | TOUC Cardiovascula                                      |   | 200000                          | Jintuo,                  |                               | <del></del>                       | 4a. Was an         | 24b. We            | ere autopsy findings available    |
| ords, aw requir nas been s   | ple            | fibrillation  |   |   |                                 |                          |                               |                                   | autopsy<br>perform | pri<br>ed? de      | or to completion of cause of ath? |
| Rec<br>The la<br>cate h  | ĕ              |   |   |   |                                 |                          |                               | 1                                 | Yes 2              | <b>✓</b> No 1      | Yes 2 No                          |
| tal Rection: The certificate ector, page   | Be             | 25. Was case referred to medical examiner?                      | 11:   |   |                                 |                          |                               | Check only or                     |                    |                    | 0.11                              |
| Vit<br>hysic<br>this c   | 70 6           | 1 Yes 2 No  | Hospital: 1 Inpatient                                   |   |                                 | DOA                      |                               | Nursing Hom                       |                    | esidence 6         | Other:                            |
| of<br>ing PP<br>After<br>funeral   |                | 27. Manner of Death  1 ✓ Natural 5 Pending                      | 28a, Date of Injury<br>(Month, Day, Year)               | 28b. Time                               | of Injury                       |                          | iry at Work?<br>Yes 2         |                                   | Jescribe no        | w injury occurred  | _                                 |
| ttend<br>death.<br>ctor:   | atic           | 2 Accident Pending  | ation   |   |                                 |                          |                               |                                   |                    | and Number         | or Rural Route Number, City       |
| Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours and are death. To the Funeral Director. After this certificate has been signed by completely filled in by the funeral director, page 2 should be detacled.   | Certification: | 3 Suicide 6 Could no determin                                   |   | - At home, farm,                        | street, tactor                  | y, onice i               | oullaing, etc                 |                                   | r Town, Sta        |                    | of Rulai Rodio Rumber, eny        |
| Spita<br>hours<br>meral<br>y fille   | Cel            | 4 Homicide  | (0,000,00)  |   |                                 | f                        | -1                            | and due to                        | the enure          | (c) and manner s   | es stated                         |
| D<br>To the Hospital<br>within 24 hours<br>To the Funeral<br>completely filled   | ledical        | (Check only 1 Certifying Physical Control one) 2 Medical Examin | cian: To the best of my kr<br>er:On the basis of examin | nowledge, death o<br>ation and/or inves | ccurred at th<br>tigation, in m | ie time, a<br>1y opinior | ate and place<br>n, death occ | ce, and due to<br>curred at the t | ime, date ar       | nd place, and du   | e to the cause(s)                 |
| To t<br>with<br>To t   | Med            | 29b. Signature and title of certifier                           | and manner stated.                                      |   |                                 |                          | se number                     |                                   |                    |                    | d (Month, Day, Year)              |
|  | _              | 0   | utimo.  |   |                                 |                          | M.E.                          |                                   | }                  | February 10        | , 2008                            |
| 4  |                |   |   | h (Item 23n)                            |                                 |                          |                               |                                   |                    |                    |                                   |
| 10   |                | 30. Name and address of person who Donna M. Vincenti, MD        | o completed cause of deal<br>Assistant Medical          |   | 111 Penn                        | Street                   | t, Baltimo                    | ore, MD 21                        | 201                |                    |                                   |
| <u> </u>   | tate           |   | 32. Registrar's   | Signature                               |                                 |                          |                               |                                   |                    |                    |                                   |
|  | strar          | L to by T & 7131  | S STATE OF S  | A Alexa                                 | BALL OF                         |                          |                               |                                   |                    |                    |                                   |

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** shillds nez February 12008 8:17 AM 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore N/A Bon Secours Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday, **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 M 2 L Director 219-38-3329 May 20, 1942 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location Show 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the Medical Exa<u>miner must be notified at</u> 1 **X**es 2 No Director Maryland N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 38 North Morley Street 21229 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 □ Yes 2 □ Nyo Baltimore, Maryland 21215-0036 Specify þ Specify 3 Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) University Md-College Park Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be finance to and Mental F Be Willie Howard Beatrice Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum 38 North Morley Street Baltimore, Maryland 21229 Beatrice Deshields Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 02/16/08 Lansdowne, Maryland Mt Zion Cemetery 21. Signature of Functor Service Licensee 22. Name and Address of Facility 23a. Part1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) acute Physician Sorte 5 4hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 2 🗆 No P.O. the detached 9 Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate Division or Vital 1□ Yes 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2**5** No 2 1 ☑ Inpatient 2 ER/Outpatient 3 🗆 DOA 28a. Date of Injury (Month, Day 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funeral Certification: or Attending Year) 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29c. License number title of certifier 29d. Date signed (Month, Day, Year) 2,008

State Registrar 31. Date filed (Month, Day, Year)

FEB 1

DHMH 17 Rev 1/2001

Street

timore, Maryland

80, Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

2000 West

Baltimore

32. Egistrar's Signature

|  |                                   | 1 - For<br>State<br>Registrar  |  |  |  | artment of Hertificate of E  |  | R   | eg. No.   | JUO  | 0425  |
|--|-----------------------------------|--|--|--|--|--|--|---|---|--|---|
| Physic   | ian                               | Decedent's Name (First, Mide   | - ni i   |  |  |  |  | 2. Date of Deat<br>Month  | Day   | Year   | 3. Time of Death  |
| /Medi  | cal                               | Frederick L. ]   |  |  |  | 4b. City, Town, or   | Location of Dooth  | 02  | 11 10 CO  | 200 8<br>unty of Death   |   |
| Exami  | ner                               | 4a. Facility Name (If not instituti  |  |  | 0 <b>10 4</b> 0 4 4  |  |  |   |   |  |   |
| Funeral  |                                   | Baltimore Was  | 6. Sex   | 7. Age (In yrs.  |  | Glen Burn  | If Under 24 Hrs.   | 8. Date of Birth  |   | e Arun<br>9. Birth   | place (State or Fore<br>intry)  |
| Director   | ,                                 | 213-32-2885  | 1 <b>X</b> M 2 □   | F 72   | Yrs.   | Months Days  | Hours Min.   | (Month, Day, May 8,   |   | MD   | muy)  |
| ath with the Maryland<br>23a or 28a-f show   | į                                 | Usual Residence of Decedent  10a. State  10b. Count  | у  | 10c. Cit   | y, Town or Lo  | ocation  |  |   |   |  | 10d. Inside City Lim  |
| the M  | Director                          | MD Anne A  | Arundel_   | G1er   | n Burn   | 10f. Zip Code  |  | 1   | On Citizen  | of What Cou  |   |
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| death<br>ma 2;   | Funeral                           | 806 Scott Circ   | 12. Was [  | Decedent Ever in U.  | S. 13.   | 21060 Was Decedent of His  | spanic Origin? (Spe  | cify Yes or No-   |   | Race - Ameri   |   |
| or its   | F                                 | 1 ☐ Never Married 2 ☑ Ma   | rried 1 TYY  | d Forces?<br>′es 2 ⊡ No<br>s. Give   | 1  | If Yes, specify Cubar  |  | Hican, etc.)  |   | Black, White   |   |
| ural',   | d by                              | 3 Widowed 4 Divorce  |  | or Dates:  |  | 1 ☐ Yes 2 📉 No   | Specify:   |   |   | ecify: Whi   |   |
| within 72 hours after death with the Maryland<br>ene.<br>than "natural", or itama 23e or 28e-f show<br>na Musical Examinat   | Completed                         | 15. Decede<br>(Specify only high<br>Elementary/Secondary (0-12)  | 1  | ted)<br>ge (1-4or 5+)  | (Give  | dent's Usual Occupa<br>kind of work done di<br>DO NOT use retired)   | uring most of workir   | ng  | 16b. Kind   | of Business/Ir   | ndustry   |
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| ibe fi   | Be                                | 17. Father's Name (First, Middle   |  | 0  |  |  | 18. Mother's Name  |   | иалдел Зи   | тате)  |   |
| thould Me mark mark  | 2                                 | Frederick DeBa   |  |  | 19h. Mailir  | ng Address (Street a   | Mary Lea:  |   | City or To  | own. State. Zi   | p Code)   |
| lith ar<br>27 is<br>r trau   | 1 5                               | Mrs. Janice De   |  |  |  | Scott Circ   |  |   |   |  | ,   |
| f Hea<br>f Hea<br>itam   |                                   | 20a. Method of Disposition   | :Dalblet   | 20b. P   | lace of Dispo  | osition (Name of matory or other place   | D  | ate   |   | ion - City or T  | own, State  |
| Page<br>ient o<br>nt: If<br>ry or  | 1                                 | 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other  |  | rom State  | •  | ke Cremati   |  | ary 15.   | Stew  | ensvil   | 1 a MD  |
| partm<br>porta   |                                   | 21. Signature  |  | One  |  | 2. Name and Address  |  |   | SW,   | Glen B   | urnie, MD   |
| 8253   | 1 0                               | 1 Comme  |  | M0141  |  | ingleton I   |  |   |   |  |   |
| Physician /Medical Examiner  | Examiner                          | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b  | e to (or as a consequence to (or a))).   | uence of):<br>uence of):   | Como   | <u> </u>   |   |   |  |   |
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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 23:06 PM **Physician** 2008 EDWARDS FEBRUARY 09 DENNIS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) Examiner BALTIMORE THE JOHNS HOPKINS HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1-20-1954 5. Social Security Number 6. Sex **Funeral** Days Hours Min. 1**∑**M 2□F 213-64-5383 Director MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show Pages 1 and 2 should be filled within 72 hours after death with the Marylan nent of Health and Mental Hygiene, and with it is the and Zilan marked other than "natural", or frems 23a or 28a f show any or other traumatic avant, I an Medical Esammer must be mortified. 1 XYes 2 No Directo N/A Balto MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21202 U S A Court 1409 Townway Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Yes 2 No FYes, Give Year or Dates: Never Married 2 Married 3 Widowed 4 Divorced filed within 72 hours after byr 1 Yes 2 No Specify: Specify Black Maryland 21215-0036 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) N/A College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emma Rose Charles Edwards, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles Edwards, Sr-Father 1409 Townway Court Balto, MD 21202 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 □ 8urial 2 □ Cremation 3 □ Removal from State permit. Page Department Important: If any injury or once. 2-19-2008 Owings Mills, MD March F/H East 4 ☐Donation 5 ☐ Other (Specify) Garrison Forest March F/H 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MD 21202 1101 E. North Avenue Balto, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pulseless Activity Arrest 1 hour **Physician** Electrical resulting in death) /Medical Examiner hours Lactic ancl Metabolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine hours The law requires that the death certificate be executed 168 Cellular attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Year Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No ed by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Tes 2 No 3 Probably 4 Munknown Immunodeficiency Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 2 No 1 Tes certificate 1 ☐ Yes or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Shaline Rao: MEDICAL DOCTOR RES-000 FEBRUARY 09 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHALINE RAD, THE JOHNS HOPKINS HOSPITAL, WOO NORTH WOLFE STREET, BALTIMURE MARYLAND 21281 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 mark) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician <u>1:</u>20 <u>James A. Elliott</u> February 6, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice
5. Social Security Number 6. Sex Baltimore n/a If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Director 78 6/20/29 Panama Cannal 214-26-9161 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at ance. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 No Director n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 USA 2632 Lehman Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Paint Factory 8 Shipping Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) America Elliott John G. Elliott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Elliott / Nephew 2632 Lehman Street Baltimore, Maryland 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 th Other (Specify Entombment Loudon Park Cemetery 2/11/08 Baltimore, Maryland 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licens 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Immediate Cause (Final Physician metastatic Unknown Primary I months Bone disease or condition resulting in death) Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Ves 2 No or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Diother (Specify) Hers Pic & 1 Tes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 ☐ Pending investigation s after dec. ral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Medical ( 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Harld a Straffer

State Registrar Juseph Richay Hespice Baltimon ND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C

31. Date filed (Month, Day, Year) 2008

5tandiford

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 2008 February /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death County of Death **Examiner** BURNIE RUNDE TIEN NNE If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) ast birthday Social Security Number Funeral Days **1** M 2 □ F Hours 68 Vrs Director Oct 2, 1939 ΗD 216-36-4642 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Glen Burnie, MD 21060 Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 818 Dale Rd 21060 USA Completed by Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Yes 2 No Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 🙀 No Specify 3 ☐ Widowed 4 ☐ Divorced White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Plant Manager 12 4 Copper Refinery other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian M. Hutton Wilbur F. Emge is marked ၀ Health and No. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 818 Dale Rd., Glen Burnie, MD 21060

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date Linda Emge Wife Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb 13, 2008 Glen Haven Cemetery Glen Burnie, MD 21061 4 Donation 5 Other (Specify) 21. Sign vive o Funeral Service Lice Se 22. Name and Address of Facility
Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD 21061 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death Enter the disease, or , or heart failure. List Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or nijur) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 98 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Day Month Year in the past 12 months? ☐Yes 2☐No 9 ☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? Ves 2 No certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ this 27. Manner of Death 1 Natural 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After it Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 24285 Charles wiles Glan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Burnia Bultimore Washington Medical Canter 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1- State amend #20b Per FH g876 2/20/08 entificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death TEBRUARY 10 2008 **Physician** Evans 4:09 AM Dolores /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner TEDICAL LENTER OLL 
7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 13 BALTIMORE WASHINGTON MEDICAL CENTER ANNE ARUNDEL 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🐼 F 213-34-6537 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heaith and Mental Hygiene.

nt: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits Items 23a or 28a-f show ner must be notifled at 1 ☐ Yes 2 ☑ No Director Anne Arundel Glen Burnie Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 109 St. James Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. event, the Medical Examiner 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Elizabeth James F. Markley Savage 힏 Important: If item 27 is marke any Injury or other traumatic once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 St. James Drive, Glen Burnie, III 2100.

of Disposition (Name of Feb. 19 to 2008 | 200. Location - City or Town, State Raltimore, Maryla Hallam Evans Jr. (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery Baltimore, Maryland 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the divease, or complication what caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic lung cancer **Physician** /Medical Due to (or as a consequence of): Examiner pheumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Physician/Medical attending pt 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 1 Yes 2 No 9 Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No s certificate ha irector, page 2 the Hospital or Attending Physician: In 24 hours after death.

the Funeral Director: After this certifica 24 hours after deatn. re Funeral Director: After this certifical eletely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Yes 20 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only Medical and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ం D66186

Registrar DHMH 17 Rev 1/2001

State

Solulan

31. Date filed (Month, Day, Year)

HOSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

20161-5803

Solevah Groves

Glen Burnie, MD

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

|                         |  |                  | for State Registrar  | State of Marylar   |  | ent of Health and atte of Death  | •   |   | 04260  |
|-------------------------|--|------------------|--|--|--|--|---|---|--|
| *                       | Physic   |                  | 1. Decedent's Name (First, Middle, Last, Edward T.   | Faust  |  |  | 2. Date of Death Month Da                               | ay Year   | 3. Time of Death                                   |
|                         | /Medi<br>Examir<br>Funeral   |                  | 4a. Facility Name (If not institution, give by Lne 5 is HL cul for 5. Social Security Number 6. Second   | street and number)  A Care  7. Age (In yrs.  | /3<br>// // // If Und                                | y, Town, or Location of Dea<br>O DK In Pa<br>ler 1 Year If Under 24 Hrs  | th 40   | County of Death                                       | runde/   |
| 8                       | Director   |                  | Usual Residence of Decedent  | 3M 2□F 74  | Yrs. Month   | s Days / Hours Min   | 8. Date of Birth<br>(Month, Day, Year                   | 33 New  | York   |
|                         | e Marylar<br>8a-f show   | ctor             | Md. Anne A   | 1 0  | ity, Town or Location<br>Irn dale                    |  |   |   | 1 Yes 2 LA   |
|                         | ath with the 23a or 2  | Funeral Director | 340 Wolham   | Ave  |  | Zip Code<br>21061  |   | itizen of What Cour                                   |  |
| 5-0036                  | within 72 hours after death with the Maryland<br>ene.<br>than "natural', or items 23a or 28a-f show<br>the Mudical Examiner must be notilied at  | þ                | 11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced  | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 DYS 2 No<br>If Yes, Give<br>Year or Dates:              |  | edent of Hispanic Origin? (specify Cuban, Mexican, Puel<br>2 No Specify: | Specify Yes or No-<br>to Rican, etc.)                   | 14. Race - Americ<br>Black, White,<br>Specify: /3 / q | etc.   |
| 21                      | vithin 72 ho<br>ne.<br>han "natu   | Completed        | 15. Decedent's Edu<br>(Specify only highest grade<br>Elementary/Secondary (0-12)   |  | - 1  | vork done during most of wa<br>use retired)                              | 16b. I  | Kind of Business/Ind                                  | ,  |
| Maryland 21             | iges 1 and 2 should be filed within 72 hours after death with the Marylar It of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event. It a Mudical Examiner must be notified at | To Be Col        | 12<br>17. Father's Name (First, Middle, Last)<br>Frank Fans  | +  | E lea  | 18. Mother's Na  | me (First, Middle, Maide                                | ,   | <u></u>  |
| - 5                     | 1 and 2 short<br>Health and N<br>Iem 27 is ma  |                  | 19a Informant's Name/Relationship (Ty<br>Sandra Fanst  | pe, Print)<br>Wife   | 19b. Mailing Addres                                  | ss (Street and Number or R   | ural Route Number, City                                 | or Town, State, Zip                                   | Code)  |
| Baltimore               | Pages 1<br>nent of He<br>ant: If Iten<br>ary or oth  |                  | 20a. Method of Disposition<br>1 ☑Burial 2 ☐ Cremation 3 ☐ R<br>4 ☐ Donation 5 ☐ Other (Specify)  | emoval from State  | Place of Disposition (Accemetery, crematory of       | r other place)   | 0   | ocation - City or To                                  | own, State   |
| Balt                    | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.   |                  | 21. Sign (1) e of Funera Service Licens  | Handan   | Carlt<br>1701  | and Address of Fability  | st. Balto   | rul Seri  | ice P.A  |
|                         | Physician<br>/Medical  |                  | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)              | ne cause of each line.  LEVE by  | ROVASCUL   | ode of dying, such as cardia  AR DISEA                                   |   |   | Approximate<br>Interval Between<br>Onset and Death |
|                         | Examiner   | e.               | Sequentially list conditions,  | Due to (or as a consect).  | ~  |  |   |   |  |
| _^                      | be executed<br>ician and<br>burial-transit   | Examiner         | Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consec   | quence of):  |  |   |   |  |
| 68760,                  | ys<br>e  | cai              |  | l  |  |  |   | r   |  |
| P.O. Box                | The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the  | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous 9 ☐ Unknown | al death 3 □Ectopic                                  |  |   | 23d. Date of delive<br>Month                          | ary<br>Day Year                                    |
| rds, P                  | w requires that<br>been signed to<br>should be det   | by               | Part II. Other significant conditions con  | tributing to death but not res   | sulting in the underlying                            | cause given in Part I.   |   | use contribute to the                                 | ne cause of death?                                 |
| al Records,             | ician: The law re-<br>certificate has bee<br>ector, page 2 sho   | Completed        |  |  |  |  | 24a. Was an autopsy performed?                          | prior to cor<br>death?                                | psy findings available mpletion of cause of        |
| Vital                   | Physician:<br>this certific<br>ral director,   | Be               | 25. Was case referred to medical sexaminer?  | ospital:   |  | 104  | ath [Check only one]                                    |   |  |
| of                      | Phys<br>r this<br>ral di   | : To             | 1 ☐ Yes 2 🕵 No   | 1 Inpatient 2  | ER/Outpatient 3 1                                    | OUA 4 Nursing I  | dome 5 Residence  |   | (Y)  |
| Division                | tending Phyleath.<br>Ior: After thi<br>the funeral   | catior           | 1 Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be  | (Month, Day Year)  | Injury<br>M  | 28c. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No                                |   |   |  |
| Divi                    | To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the funer  | Certification:   | 4 Homicide determined  | 28e. Place of Injury - At h<br>building, etc. (Special   | (y)  |  | 28f. Location (Street a<br>City or Town, Stat           | 'e)   |  |
|                         | the Hosp<br>in 24 hou<br>the Fune<br>apletely fi   | edicai           | 29a. Certifier (Check only one)  (Check only one)  | sician: To the best of my kno<br>ner: On the basis of examina<br>and manner stated.                      | owledge, death occurre<br>ation and/or investigation | d at the time, date and place<br>on, in my opinion, death occ            | e, and due to the cause(s<br>urred at the time, date an | i) and manner as st<br>id place, and due to           | tated. o the cause(s)                              |
|                         | To To COLL   | ×                | 29b. Signature and fittle of certifier   | Sellen   |  | 9c. License number  D31136   |   | ate signed (Month, )                                  | - /  |
| ,                       | 341  |                  | 30. Name and address of person who co  | mpleted cause of death (Iter   | m 23a) (Type, Print)                                 | D31136<br>HLDRIDE R  | BATIA   | HORIS IN  | 10 21221   |
| 15.<br>- (4.)<br>- (4.) | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year)  | 2. Degistrar's Signa   | ature  |  | TOACI (A  | Total por   | 1 2136   |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 00:50 am 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hookins Bayrien Care Center 5. Social Security Number | Sex | 7. Age (In vrs. last Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Director 80 217-22-1364 6-10-1927 MD Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show YYes 2□No **Funeral Director** MD N/ABalto 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or idloai Examiner must be i 925 N. Broadway 12. Was Decedent Ever in U.S. Armed Forces? 21205 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Be Completed th and Mental Hygiene.

7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U. S. Government Laundry Worker 7th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie Lemmon John Glover ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 925 N. Broadway Balto, Health a Doris Fitzgerald -Wife MD 21205 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages ' Department of Important: If it any injury or conce. 1 Nurial 2 □ Cremation 3 □ Removal from State Baltimore National2-15-2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H East 21. Signature of Funeral Service Licensee 1101 E. north Avenue Balto, MD 21202 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) tspiration Phenmonia Physician day /Medical Due to (or as a consequence of): Examiner eo mye Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner vascular disease The law requires that the death certificate be executed terioscleratic burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ervica1 SDIMA cord Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 24a. Was an autopsy performed′ 1 Yes 2 → cerebrovascula-To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined n 24 hours after des he Funeral Directo nletely filled in by th 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 hor To the Fune completely fi (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 059562

State Registrar

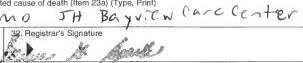
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

60026190

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO



Hopland Bays, Extende

|                     |  |                | For State  | State of Ma  | -                   | epaπmen<br>C <i>ertificat</i>     |                               |   | _                      | giene<br>Reg. No | * ) [ ] [ ] [ ]            | 04262                                 |
|---------------------|--|----------------|--|--|---------------------|-----------------------------------|-------------------------------|---|------------------------|------------------|----------------------------|---------------------------------------|
| -                   | - 1  |                | Registrar  1. Decedent's Name (First, Middle, Last)  |  |                     | Jorimodi                          | 0 0. 2                        |   | 2. Date of De          | ath              |                            | 3. Time of Death                      |
| .4                  | Physicia<br>/Medic   |                | DANIEL   | R.   | GRE                 | CO                                |                               |   | Month<br>FEBRUA        | RY Da            | 10 2008                    | 3:20 P M                              |
|                     | Examin   |                | 4a. Facility Name (If not institution, give  |  |                     |                                   |                               | ocation of Death                                  | 1                      |                  | County of Deat             | ו                                     |
| - 6                 | · · · · · · · · · · · · · · · · · · ·  | .8             | FOREST HILL HEALTH  5. Social Security Number 6. Se |  | (In yrs. last birth |                                   | OREST                         | If Under 24 Hrs.                                  | 8. Date of Bir         |                  | HARFORD                    | nplace (State or Foreign              |
|                     | Funeral<br>Director  |                |  | M 2□F  |                     | months Months                     |                               | Hours Min.  | (Month, Da<br>08/30)   | ay, Year         | ) Co                       | w Jersey                              |
|                     | yland<br>Iow<br>at   | Ì              | 10a. State 10b. County   |  | 10c. City, Town     | or Location                       |                               |   | ·                      |                  |                            | 10d. Inside City Limits               |
|                     | a-f sh   | ctor           | MD Harford   |  | Fallst              | on                                |                               |   |                        |                  |                            | 1 □Yes 2X No                          |
|                     | or 28  | Director       | 10e. Street and Number   |  |                     | 10f. Zip                          | Code                          |   |                        | 10g. Ci          | tizen of What Co           | untry?                                |
|                     | s 23a  | eral           | 528 Arama Drive  | 12. Was Decedent E   | vor in IIS          |                                   | 1047                          | nanic Origin? (S)                                 | necify Ves or No       |                  | J.S.A.<br>14. Race - Amer  | ican Indian                           |
| 36                  | be filed within 72 hours after death with the Maryland ital Hygiene.  Id Hygiene.  Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral     | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  | Armed Forces? 1 X Yes 2 □ No If Yes, Give                        | 0                   | If Yes, spe                       |                               | panic Origin? (S)<br>, Mexican, Puerl<br>Specify: | o Rican, etc.)         |                  | Black, White               | e, etc.                               |
| Maryland 21215-0036 | Phour  |                | 15. Decedent's Edu   | Year or Dates:   | 16a. [              | Decedent's Usu                    | al Occupat                    | ion   |                        | 16b. F           | WI1<br>Kind of Business/i  | ite<br>ndustry                        |
| 215                 | hin 72<br>9.<br>an "na<br>Medi   | Completed      | (Specify only highest grade<br>Elementary/Secondary (0-12)   | e completed) College (1-4or 5+                                   | .) (                | Give kind of wo<br>life. DO NOT u | rk done du<br>se retired)     | ring most of wor                                  | king                   | Depa             | rtment o                   | of                                    |
| 2                   | ed wit<br>ygjene<br>yer the  | Com            | 12   | 4  |                     | gricult                           |                               | Ingineer  |                        | Agr              | ciculture                  |                                       |
| and                 | be eve   | Be             | 17. Father's Name (First, Middle, Last)  |  |                     |                                   | 1                             | 8. Mother's Nam                                   |                        |                  | n Surname)                 |                                       |
| $\frac{3}{2}$       | d 2 should be filed<br>th and Mental Hygi<br>7 Is marked other<br>traumatic event, t   | 은              | John Greco  19a, Informant's Name/Relationship (Ty   | ne Print)  | 19h                 | Mailing Address                   | : (Street an                  |   | alentin                |                  | or Town, State, Z          | (in Code)                             |
|                     | a s a  |                | John Greco (son  | •  |                     | •                                 |                               | ve – Fa   |                        |                  |                            | 21047                                 |
| re,                 | ← I a ≠  |                | 20a. Method of Disposition   |  | 20b. Place of I     | Disposition (Nar                  | ne of                         | ï   | Date                   |                  | ocation - City or          |                                       |
| Ē                   | Pages<br>nent of<br>ant; If its<br>any or o  |                | 1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other ( <i>Specify</i> )   | lemoval from State   | 1                   |                                   |                               | į   | 1/2008                 | Bal-             | timore.                    | Marvland                              |
| Baltimore,          | permit. Pag<br>Department<br>Important: f<br>any Injury o  |                | 21. Signature of Funeral Service Licens  | eselvi   |                     |                                   |                               |   |                        |                  |                            | Maryland<br>l Home, P.A.<br>and 21087 |
| 9                   | 13.5   |                | 23a. Part1. Enter the disease, or compl<br>shock, or heart failure. List only or   | ications that caused I   | the death. Do no    |                                   |                               |   |                        |                  | Acces and                  | Approximate<br>Interval Between       |
|                     | Physician  |                | Immediate Cause (Final disease or condition  |  | mores               | 3                                 |                               |   |                        |                  |                            | Onset and Death                       |
|                     | /Medical<br>Examiner   |                | resulting in death)  | Due to (or as a  | consequence of      | f):                               |                               |   |                        |                  |                            |                                       |
| 3                   | 8  | <u>-</u>       | Sequentially list conditions,  | Due to (or as a  | consequence of      | f):                               |                               |   |                        |                  |                            |                                       |
|                     | uted<br>d<br>ansit   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Figure 1) that initiated events   |  | ,                   |                                   |                               |   |                        |                  |                            |                                       |
| o,                  | ifficate be executed<br>g physician and<br>as the bunal-transit  |                | resulting in death) Last   | Due to (or as a  | consequence of      | f):                               |                               |   |                        |                  |                            |                                       |
| 68760,              | ate be<br>hysici<br>the bu   | edical         |  | d  |                     |                                   |                               |   |                        |                  |                            |                                       |
|                     |  |                | IF FEMALE:   | 23c. If yes, outcome p   | of pregnancy        |                                   |                               |   |                        |                  | Dod Date of the            |                                       |
| D. Box              | requires that the death cert<br>een signed by the attending<br>hould be detached for use a   | Physician/M    | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 1 ☐ Live birth 2<br>4 ☐ Pregnant at t<br>9 ☐ Unknown             | 2 Fetal death       | 3 □Ectopic p<br>5 □ Other (sp     |                               |   |                        | 1                | 23d. Date of deli<br>Month | very<br>Day Year                      |
| P.O.                | res that the de<br>signed by the a<br>be detached  | Ph             | Part II. Other significant conditions co   | ntributing to death but  | t not resulting in  | the underlying o                  | ause giver                    | in Part I.  | 23e. Did               | tobacco          | use contribute to          | the cause of death?                   |
| Records,            | quires<br>n sign<br>ald be   | d by           |  |  |                     |                                   |                               |   | 10                     | Yes 2            | 2 No 3 Pr                  | obably 4 Unknown                      |
| 000                 |  | Completed      |  |  |                     |                                   |                               |   | 24a. Was               |                  | 24b. Were au               | topsy findings available              |
|                     | The lavete has the   | mo             |  |  |                     |                                   |                               |   | auto<br>perf<br>1⊟ Yes | ormed?<br>2√□N   | death?                     | completion of cause of<br>2 No        |
| Vita                | sician; The<br>certific te<br>rector, pag  | Be             | 25. Was case referred to medical examiner?   |  |                     |                                   |                               | 26. Place of Dea                                  | th (Check only         |                  |                            |                                       |
|                     | Physle<br>this c   | 은              | 1 ☐ Yes 2 ☐ No   | lospital:<br>1 ☐ Inpatier<br>28a. Date of Injur                  | nt 2 ☐ ER/Outp      |                                   |                               | 4 Lixursing H                                     | lome 5 Res             |                  | 6 □Other (Spec             | cify)                                 |
| OU O                | ding Ph<br>h.<br>After thi<br>funeral  | ion:           | Natural 5 ☐ Pending  | (Month, Day  |                     | jury M                            | 28c. Injury<br>Work?<br>1 □ Y | es 2 □ No   | 260. Describe          | now inju         | ury occurred               |                                       |
| Division or         | l or Attendafter death<br>Director:  | Certification: | 3 Suicide 6 Could not be   | 28e. Place of injur  | ry - At home, fari  |                                   |                               |   | 28f. Location          | (Street a        | and Number or Ru           | ıral Route Number,                    |
| á                   | tal or<br>s after<br>al Dir  | Certi          | 4 ☐ Homicide aeterminea  | building, etc.   | . (Ѕреспу)          |                                   |                               |   | City or To             | wn, Sta          | ( <del>0</del> )           |                                       |
|                     | To the Hospital or Attending Physician; within 24 hours after death.  To the Funeral Director; After this certific completely filled in by the funeral director, is a small director.  | Medical (      |  | sician: To the best o<br>ner: On the basis of<br>and manner stat | examination and     |                                   |                               |   |                        |                  |                            |                                       |
|                     | To th<br>withii<br>To th<br>comp   | Me             | 29b. Signature and title of certifier  |  |                     | 29                                | c. License                    | number  |                        |                  | ate signed (Mont           |                                       |
|                     | <  |                | Dans K   | D  |                     |                                   | 033                           | 755   |                        | Fel              | Que .                      | 1,2008                                |
| ì                   | 0 X 1/2  |                | 30. Name and address of person who co  |  |                     |                                   | 7T. ATT                       | Эмп Э1  | 01/                    |                  | 3                          | 9                                     |
| Į.                  | Sta  | te             | 31. Date filed (Month, Day, Year)  |  | r's Signature ~     | אריים (איניים) – DE               | יוי עדן                       | χ, FID Δ1   | .014                   |                  |                            |                                       |
|                     | Registr  |                | FFR 1 4 2008 A   | Contract of  | R ASSISTAN          | Z. A                              |                               |   |                        |                  |                            |                                       |

|                     |   |                     | For State Registrar   | State of Ma   | -  | pariment of F<br><i>ertificate of</i>                                 |  | rientai Hyg<br>R                        | leg. No. 2008                                   | 04263  |
|---------------------|---|---------------------|---|---|--|---|--|---|---|--|
|                     | Physici   | an                  | 1. Decedent's Name (First, Middle, Las  | 1   |  |   | -  | 2. Date of Dea                          | th  | 3. Time of Death                                   |
|                     | /Medio  | cal                 | Sofiya Grir<br>4a. Facility Name (If not institution, giv   | bercy   |  | 4h City Town o  | or Location of Death                         | FERKUAR                                 | Y 11, 2008<br>4c. County of Dear                |  |
|                     | Examir  | ier                 | RUXTON OF PIKES   |   |  | PIKESVIL  |  |   | BALTIMOR  |  |
| 1                   | Funeral   |                     | 5. Social Security Number 6. S  | ex . 7. Ag  | je (In yrs. last birtho                    |   |  | 8. Date of Birth<br>Month Day<br>01/02/ | 9 Birl  | tholace (State or Foreign                          |
|                     | Director  |                     | 214-27-1314   | □м 2Д Г   | 93 Yrs                                     | · Months Buys   | Tiodio Mini.                                 | 01/02/                                  | /1915   | UKRAINE  |
|                     | /land   |                     | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City, Town o                          | Location  |  |   |   | 10d. Inside City Limits                            |
|                     | a-f sh  | ctor                | MD BALTIM   | ORE   | BALTI                                      | MORE  |  |   |   | 1 □ Yes 2 🗖 No                                     |
|                     | or 28   | Dire                | 10e. Street and Number  |   |  | 10f. Zip Code   | 01015  | 1                                       | 10g. Citizen of What Co                         | -  |
|                     | s 23a   | eral                | 6940 MARSUE DR  | IVE, #1-A   | Ever in II S                               |   | 21215  | coifu Vec or No                         |   | ISA  |
| Maryland 21215-0036 | be filed within 72 hours after death with the Maryland<br>Ital Hygiene.<br>sd other than "natural", or items 23a or 28a-f show<br>event, the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ Married 3 🛣 Widowed 4 □ Divorced   | Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:                    | No   | 3. Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes 2 No           |  | echy fes of No-<br>Rican, etc.)         | Black, Whit                                     |  |
| 15-0                | ין 22 ה<br>"natu<br>edical  | letec               | 15. Decedent's Ed<br>(Specify only highest gra  | lucation<br>de completed)   | 16a. De                                    | cedent's Usual Occup<br>ive kind of work done<br>e. DO NOT use retire | oation<br>during most of work                | ing                                     | 16b. Kind of Business                           | 'Industry  |
| 12                  | filed withir<br>Hygiene.<br>other than  | Completed by        | Elementary/Secondary (0-12)   | College (1-4or 5  | 5+) . "'                                   | HOMEM   |  |   | OWN HO  | )ME  |
| br                  | al Hyg<br>other   | Be C                | 17. Father's Name (First, Middle, Last,   |   |  |   | 18. Mother's Name                            | e (First, Middle,                       |   |  |
| ylaı                | 2 should be filed n and Mental Hygirs marked other raumatic event, It   | Tof                 | CHAIM   |   | GRINBE                                     |   | YENTA  |   |   | KINA   |
| , Mar               | nd 2 stith ar   |                     | 19a. Informant's Name/Relationship ( EMILIYA SHAPIR   |   | TER 10                                     | 307 OLDE W  | OODS WAY,                                    | COLUMB                                  |   | )44  |
| Baltimore,          | a 0   |                     | 20a. Method of Disposition  1     Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)                                 | y)  | ART TO AMUN                                | sposition (Name of<br>Comatory or other pla<br>TON - CHT2<br>CONG     | Σΰκ<br>02/13                                 | /2008                                   | BALTIMORE,                                      | , MD   |
| Bal                 | permit. Pag<br>Department<br>Important: I<br>any Injury o   |                     | 21. Signature of Funeral Service Licer  |   |  |   | STERSTOWN                                    | ROAD -                                  | SON & BROS<br>PIKESVILLE                        | ., INC.<br>, MD 21208                              |
| Я                   |   |                     | 23a. Parti. Enter the disease, or com<br>shock, or heart failure. List only   |   |  |   | ng, such as cardiac                          | or respiratory arr                      | rest,   | Approximate<br>Interval Between<br>Onset and Death |
|                     | Physician /Medical  |                     | Immediate Cause (Final disease or condition resulting in death)   | , u.  | a consequence of):                         | neine   |  |   |   |  |
|                     | Examiner  |                     |   | Dene  |  |   |  |   |   |  |
|                     | p Æ   | iner                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events |   | a consequence of):                         |   |  |   |   |  |
|                     | ecute<br>and<br>I-trans   | Examiner            | Cause (Disease or injury that initiated events resulting in death) Last   | c. Due to for as  | a consequence of):                         | Mitus   |  |   |   |  |
| 68760,              | ifficate be executed<br>g physician and<br>as the burial-transit  | al E                | (   | d   |  |   |  |   |   |  |
|                     |   | ledical             | 833   | u   |  |   |  |   |   |  |
| P.O. Box            | The law requires that the death cert ate has been signed by the attending agge 2 should be detached for use   | Physician/M         | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome<br>1 □Live birth<br>4 □ Pregnant at<br>9 □ Unknown | 2 Fetal death                              | 3□Ectopic pregnanc<br>5□ Other (specify) _                            | у  |   | 23d. Date of de<br>Month                        | livery<br>Day Year                                 |
|                     | es that<br>gned b   | by PI               | Part II. Other significant conditions   | ontributing to death b  | out not resulting in th                    | e underlying cause giv  | ven in Part I.                               | 23e. Did to                             | bacco use contribute to                         | o the cause of death?                              |
| ord                 | w requir<br>been si<br>should i   | ted                 |   |   |  |   |  | 1 U Y                                   | es 2 2 1√10 3 □ P                               | robably 4 □Unknown                                 |
| or Vital Records,   |   | Completed           |   |   |  |   |  | 24a. Was a autop: pertor                | sy prior to<br>med? death?                      | utopsy findings available completion of cause of   |
| Vita                | Physician: Th<br>r this certificate<br>ral director, pag  | Be                  | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  | Hospital:   | 00000                                      | tient 3 DOA Oth   | 26. Place of Deat                            |   |   |  |
| 0                   | g Phys<br>er this<br>eral dii   | n: To               | 27. Manner of Death   | 28a. Date of Inju   | ury 28b. Tim                               | e of 28c. Inju  | 4 Mursing Ho                                 |   | ence 6 Other (Spe                               | ecify)   |
| sion                | ending lath.<br>or: After<br>he funer   | atio                | 1 Natural 5 Pending 2 Accident investigation  |   | ly Year) Inju                              |   | Yes 2 □ No                                   |   |   |  |
| Division            | Hospital or Attending<br>24 hours after death.<br>Funeral Director: After<br>tely filled in by the fune   | Certification:      | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined  | 28e. Place of IIII  | ury - At home, farm<br>c. <i>(Specify)</i> | street, factory, office   |  | 28f. Location (S<br>City or Tow         | treet and Number or R<br>rn, State)             | ural Route Number,                                 |
|                     | To the Hospital or I within 24 hours after To the Funeral Directorpletely filled in b   | Medical C           | 29a. Certifier 1 Certifying Ph<br>(Check only one) 2 Medical Exar   | ysician: To the best<br>niner: On the basis o<br>and manner st          | of examination and/o                       | eath occurred at the ti<br>r investigation, in my                     | ime, date and place,<br>opinion, death occur | and due to the or<br>red at the time, o | cause(s) and manner a<br>date and place, and du | s stated.<br>e to the cause(s)                     |
|                     | To the within 2 To the comple   | Me                  | 29b. Signature and title of certifier   |   |  | 29c. Licens   |  | 2                                       | 29d. Date signed (Mon                           |  |
|                     | <u> </u>  |                     | - Mondy   | sent  |  |   | 53337  |   | 2-11-08   |  |
| 2                   | 7   |                     | 30. Name and address of person who Doro Hvy Seay, n   | completed cause of d  | leath (Item 23a) (Ty                       | oe, Print)  | e anz R                                      | a Homens                                | Md 21719  |  |
|                     | Sta   | ite                 | 31. Date filed (Month, Day, Year)   | 32. Registr   | rar's Signature                            | ence Sail   | , - 0,00                                     | w. Howard                               | 1.0121201                                       |  |
|                     | Registr   |                     | FEB 1 4 200   | 8 Alexan  | , 55. 100                                  | BARK  |  |   |   |  |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 FEB. ELIZABETH P. GEARE 8 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BROADMEAD COCKEYSVILLE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours 04/08/1923 MARYLAND 1 M 2 K F 244-24-2800 84 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits BALTIMORE COCKEYSVILLE 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21030 13801 YORK RD USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Nes 2 □ N 1 Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 🕱 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2YRS • Elementary/Secondary (0-12) HOUSEWIFE HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GEORGE M. ENGLAR ELIZABETH D. WALKER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNE S. POTTER (DAUGHTER) 103 GIDDINGS AVE ANNAPOLIS, MD. 21401. 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State GREEN MOUNT CREMATORY 02/11/08 BALTO CITY, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Fungtal Service Licens 22. Name and Address of Facility W. JENK YORK RD NS & SONS O 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEN-SMAK CELL CONCER OF LUNG Due to (or as a consequence of): Sequentially list conditions, if any, learning to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an . Were autopsy findings available prior to completion of cause of autopsy death? 2 No 1□ Yes 2 □ No. 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

28a-f

23a or must be

r than "natural", or items the Medical Examiner mu

n and Mental Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked othel any injury or other traumatic event, i

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

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notified

Director

Funeral

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Completed

Be

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MD

and burial-trar physician the as attending nse į signed by the a d be detached f been has page 2 certificate

that the death certificate be executed

P.O. Box 68760.

Division or Vital Records,

this funeral e Hospital or Attending P 24 hours after death. e Funeral Director; After t After

Examiner Physician/Medical

filled in by the

Completed by Be Certification: To

Medical

24 hours a completely To the I within 2 n

State

Registrar

BARBARA 31. Date filed (Month, Day, Year)

29a. Certifier

2 No

5 Pending investigation

6 ☐ Could not be determined

1 ☐ Yes

27. Man of Death

1 E Natural

2 Accident

3 Suicide

4 🗌 Homicide

(Check only one)

29b. Signature and title of certifier

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

29c. License number

Other:

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YORK RD. COCKEYSVILLE, MD. 13801 CARROLL M.D. 21030.

2 ER/Outpatient 3 DOA

28b. Time of

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

32. Registrar's Signature 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 248 tate of Warkland (898) of The 14 (898) and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician James Newton Hurst February 2 2008 3:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 ☑ M 2 🗆 F 214-34-9907 Director Maryland 67 Feb 15, 1940 Usual Residence of Decedent 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10d. Inside City Limits Director MD 1 ☐ Yes 2√ No Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 350 B Prospect Blvd #204 21701 USA d 2 should be filed within 72 hours after death v th and Mental Hyglene. Y is marked other than "natural", or items 23s traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No white Specify: Specify: Completed by 3 Widowed 4 Divorced unk 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lewis Monroe Hurst Mary Elizabeth Mansfield ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st
Department of Health an
Important: If item 27 is r
any injury or other traur Ethel M. Hurst/spouse 350 B Prospect Blvd #204 Frederick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Nonation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Funeral Sen ce Licensee LOTTATO S. Wade Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 20 **Physician** SEDSIS SPINAL WEEKS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off-Examiner Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No

be executed Box 68760. P.0. Records, Physician:

burial-transit and

cate has been signated by page 2 should b

funeral director,

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filled in by

completely

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Certification:

Medical

1 Yes

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

29b. Signature

4 Homicide

(Check only one)

31. Date filed (Month, Day, Year)

5 Pending

6 Could not be determined

investigation

1 Natural

certificate has

this

After t

e Hospital or Attending i 24 hours after death. e Funeral Director: After

To the within 2

Baltimore, Maryland 21215-0036

Division or Vital

State

DHMH 17 Rev 1/2001

Registrar

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

rederick

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

1 Dipatient

28a. Date of Injury (Month, Day Year)

and manner stated.

ller

32 Registrar's Signatu

18 18 C

me and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For state Amend PI line a-b, 24a-b, perMD, g876 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Jayden L. Hemby 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Prince Georges Prince Georges Hospital Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6 Sex 7. Age (In vrs. last birthday **Funeral** Year) Days 1 → M 2 □ F n/a Director 19, 2008 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County If Item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 TXNo Director Maryland Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8823 Heathermore Blvd. 20772 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 K Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: ģ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) n/a Infant n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ray Hemby 2 Lakishia Moncree 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health at.
Important: If Item 27 is 1
any injury or a Ray Hemby (Father) 8823 Heathermore Blvd. Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 1-25-2008 Suitland, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Transposition of great vessels** Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Congenital heart disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical as cate has been signed by the attending I page 2 should be detached for use as IF FEMALE: If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ∄X Yes -2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 ၉ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) сотпретельный filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation Injury Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) leted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

FEB

Year!

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2008

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amend Item 4a per doc 88/6 2-20-08 vt.

State of Marvland / Department of Health and Mental Hygiene | | | | | | |

|                    |  |                           | 1 _ State   |   | , , , , ,  |  |   |   | ına ivlei                    | nai i iygii  | SHOZ () (   | 3 ()  | 04267                                    |   |
|--------------------|--|---------------------------|---|---|--|--|---|---|------------------------------|--|---|---|--|---|
|                    |  |                           | Registrar  1. Decedent's Name (First, Middle  | le, Last)   | ,-,-   | Cel  | rtificate of  | Deam  | 2.                           | Date of Death  | J. No.  |   | 3. Time of Death                         | - |
|                    | Physici  |                           | Mary Kemp   | Hoos  |  |  |   |   |                              | Month<br>ebruary   |   | Year  | 1:45 A M                                 |   |
| 1                  | /Medio<br>Examin   |                           |   |   | mber)  |  | 4b. City, Town, o   | r Location of   |                              | ebruary  | 4c. County o  |   | 1:45 A                                   | - |
|                    |  |                           | 4a. Facility Name (If not institution St. Catherine St. Charles Nu  | s s Nursin  | g Cente  | r  | Emmits  | ourg  |                              |  | Frede   | erick   | 2  |   |
|                    | Funeral<br>Director  |                           | 5. Social Security Number 215–14–9753   | 6. Sex<br>1 ☐ M 2 ☑ F   | 7. Age (In yrs. I.<br>85   | ast birthday)<br>Yrs.  | If Under 1 Year<br>Months Days                            | If Under 2<br>Hours                                       | 24 Hrs. 8.<br>Min. 0         | Date of Birth<br>(Month, Day, )<br>5-27-19   | (ear)<br>022  | 9. Birthpla<br>Counti<br>Mary                                   | ace (State or Foreign<br>n)<br>1and      |   |
|                    | and and  |                           | Usual Residence of Decedent  10a. State 10b. County   | ,   | 10c. City  | , Town or Lo   | cation  |   |                              |  |   | 10  | d. Inside City Limits                    | _ |
|                    | Many<br>-1 eho   | ţ                         | MD Fred   | derick  |  | [4]=   | lkersvill   | 10  |                              |  |   |   | 1 ☐ Yes 2 📉 No                           |   |
|                    | ath with the Marylan<br>23s or 28s-1 ehow  | Director                  | 10e. Street and Number  | CLICK   |  | wa   | 10f. Zip Code   | <u> </u>  |                              | 100  | g. Citizen of Wh                                    | nat Count   | ry?                                      | - |
|                    | 23a c  |                           | 111 Greenwich   | Drive   |  |  |   | 21793   |                              |  | United  | Stat  | es                                       |   |
|                    | tems   | Funeral                   | 11. Marital Status  | Armed Fo  |  | S. 13.   | Was Decedent of H<br>f Yes, specify Cuba                  | lispanic Orig<br>an, Mexican,                             | in? (Specify<br>, Puerto Ric | y Yes or No-<br>an, etc.)  | 14. Race<br>Black                                   | - America<br>White, e   |  |   |
| 50                 | hours after death with the Maryland<br>turst', or Itema 23e or 28e-1 ehow<br>at Examinations be notified at  | by F                      | 1 ☐ Never Married 2 ☐ Mar<br>3XXVidowed 4 ☐ Divorced  | If Yes Gi   | /0   |  | 1 ☐ Yes 2x No   | Specify:  |                              |  | Specify:  | T. 7  | • •                                      |   |
| 5-003 <del>6</del> | 2 hou<br>atura<br>cel E  |                           | 15. Deceden   | nt's Education  | u103.  | 16a. Deced   | dent's Usual Occup  | ation   | · · · · · ·                  | 16   | 6b. Kind of Bus                                     |   | lite<br>ustrv                            | _ |
| 213                | within 72<br>ene.<br>than "na!   | Completed                 | (Specify only highe<br>Elementary/Secondary (0-12)  | st grade completed) College (   | I-4or 5+)  | (Give  | kind of work done<br>DO NOT use retired                   | durina most   | of working                   |  |   |   | ,  |   |
| 7                  | filed wil<br>Hygiene<br>Sther the  | Con                       | 12  |   |  |  | Homen   | naker   |                              |  | Own   | Home  | <u> </u>                                 |   |
| and                | \$ 7 8 8   | Be                        | 17. Father's Name (First, Middle,   |   |  |  |   | 18. Mother  | r's Name (F                  | irst, Middle, Ma   | aiden Surname                                       | )   |  |   |
| 2                  | should tind Ment<br>marked<br>umatic   | 10                        | Louis E. Kem  | 1   |  |  |   |   |                              | tha I.   |   |   |  | _ |
| <u>8</u>           | d 2 st<br>th and<br>t7 is r<br>traur   |                           | 19a. Informant's Name/Relations   |   |  |  | ng Address (Street  |   |                              |  |   |   | Code)                                    |   |
| ā,                 | s 1 and 2 should<br>f Health and Mer<br>item 27 is marke<br>other traumatic  |                           | Phyllis Tenney 20a. Method of Disposition   | - Daugnt  | 20b. PI  | ace of Dispo   | Sandlight sition (Name of                                 |   | Date                         | 20   | c. Location - C                                     |   | vn, State                                | - |
| Ē                  | mit. Peges<br>pertment of l<br>contant: If it<br>injury or o   |                           | 1 Strail 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S  |   | State  | •  | natory or other place<br>stine Cen                        | , I E   | ebrua<br>12, 2               | ry   | lkridge   |   |  |   |
|                    | partm<br>ports   |                           | 21. Signature of Funeral Service  |   | M00053   |  |   |   |                              |  | fman Fi   | inera   | 1 Home at                                |   |
| Ď                  | E S E S S  |                           | Hack 1  | 1.12wx  | aun  |  |   |   |                              |  |   |   | MD 21075                                 |   |
|                    |  |                           | 23a. Part1. Enter the disease, or shock, or heart failure. List   | complications that of   | aused the death<br>ach line.   | . Do not ent   | er the mode of dyin                                       | g, such as o  | cardiac or re                | spiratory arres  | t,  |   | Approximate<br>Interval Between          |   |
|                    | Physician  |                           | Immediate Cause (Final disease or condition   | · Cu  | d Sto  | ase  | -1)0  | 71.2  | 127                          | 101.   |   |   | Onset and Death                          |   |
|                    | /Medical<br>Examiner   |                           | resulting in death)   | Due to  | or as a consequ  | enge of):  |   | u   | 7                            |  |   | -   |  | - |
|                    | 1  | -                         | Sequentially list conditions, if any, leading to immediate  | b. Overto   | or da d consequ  | 45   |   |   |                              |  |   |   |  |   |
|                    | nst A de   | Examiner                  | cause. Enter Underlying Cause (Disease or injury  | <b>4</b>  |  |  |   |   |                              |  |   |   |  |   |
| <b>5</b>           | be executed icien and burial-transli   | Exa                       | that initiated events<br>resulting in death) Last   | C. Due to   | or as a consequ  | ence of):  |   |   |                              |  |   |   |  |   |
|                    | et sys   | cal                       |   | d   |  |  |   |   |                              |  |   |   |  |   |
| 0                  | ntifica<br>ing ph  |                           | IF FEMALE:  |   |  |  |   |   |                              |  |   |   |  |   |
| Ŝ                  | ath ce   | lan/                      | 23b. Was decedent pregnant in the past 12 months?   | 1 ☐ Live b  | come of pregnar<br>irth 2 ☐ Fetal  | death 3  | Ectopic pregnancy   |   |                              |  | 23d. Date<br>Mont                                   |   | y<br>Day Year                            |   |
| -<br>5             | he de<br>the a   | Physician/Med             | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4∐Pregn<br>9☐Unkno  | ant at time of de<br>own   | ath 5□   | Other (specify)   |   |                              |  | NOTE  |   | ody rodi                                 |   |
| ŗ                  | that the by detact   |                           | Part II. Other significant condition  | ons contributing to de  | eath but not resu  | Iting in the ur  | nderlying cause give                                      | en in Part I.   |                              | 23e. Did toba  | cco use contrib                                     | ute to the  | cause of death?                          | - |
| orus,              | quires<br>n sign   | d by                      | HyperTE   | usio  | u  |  |   |   |                              | 1 🗌 Yes  | 2/2 No 3  | ☐ Proba   | bly 4 □Unknown                           |   |
| 2                  | s bee  | lete                      | Chianic   | leid  | nin  | di   | 0001  | 2.  |                              | 24a. Was an  | 24b. W  | ere autop   | sy findings available                    | _ |
| ב                  | The Iz   | Completed                 |   |   | 7  |  |   |   |                              | autopsy  |   |   | pletion of cause of                      |   |
|                    |  | OI                        |   |   | ,  |  | - Jeny  |   |                              | performe   | d? de   | ath? .  | No.                                      |   |
| <u> </u>           | artifice<br>ctor, p  | 36                        | 25. Was case referred to medical  |   |  |  |   | 26. Place   | of Death (C                  | performe<br>1 ☐ Yes 2 \$<br>heck only one)   | d? de<br>4No 1E                                     | ath? .  | No.                                      | - |
| י אונש             | hysician:<br>his certifice<br>il director, p   | To Be                     | examiner?<br>1 ☐ Yes 2 No   | Hospital: 1 □ I   | npatient 2 E   | ER/Outpatien   | 1 3 DOA Othe  | or .  |                              | performe<br>1 ☐ Yes 2  | d? de<br>4.No 1.                                    | ath?<br>Yes 2   |  | _ |
| 10 VII             | ing Physician:<br>After this certifice<br>uneral director, p   | ဥ                         | examiner? 1 □ Yes 2 □ No  27. Manner of Death 1 ➢ Natural 5 □ Pendin  | Hospital: 1 1 1   |  | ER/Outpatien<br>28b. Time of<br>Injury                         | 28c. Injun<br>Worl  | er: A Nur<br>v at<br>k?                                   | sing Home                    | performe<br>1 ☐ Yes 25<br>heck only one)   | d? de<br>4No 1 □                                    | ath?  |  |   |
| ואווו טו אוומו     | ttending Physicien:<br>death.<br>tor: After this certifice<br>the funeral director, i  | ဥ                         | examiner?  1 Yes 2 No  27. Manner of Death  1 Alatural 5 Pendin  2 Accident investig  3 Suicide 6 Could   | Hospital: 1 1 28a. Date of (Mont) gation not be   | of Injury<br>h, Day Year)  | 28b. Time of<br>Injury   | 28c. Injun<br>World<br>M 1                                | er: Nur   | sing Home<br>28d             | performe  1 Yes 2  heck only one)  5 Residence  Describe how   | d? de 1 □   | ath? Yes 2  |  |   |
| DIVISION OF VITAL  | I or Attending Physicien:<br>effer death.<br>Director: After this certifica<br>I in by the funeral director, I   | ဥ                         | examiner? 1  Yes  | Hospital: 1 1 28a. Date of (Mont) gation not be interested 28e. Place   | of Injury<br>h, Day Year)  | 28b. Time of Injury  | 28c. Injun<br>Worl  | er: A Nur<br>v at<br>k?                                   | sing Home<br>28d             | performe<br>1 □ Yes 2 s<br>heck only one)<br>5 □ Residend  | d? de   | ath? Yes 2  |  | _ |
| DIVISION OF VITAL  | ospital or Attending Physician: hours efter death. nerel Director: After this certifice y filled in by the funeral director.   | Certification: To         | examiner?  1 Yes 2 No  27. Manner of Death  1 Autural 5 Pendin investig  2 Accident investig  4 Homicide 6 Could determ  29a. Certifier   | Hospital: 1 1 28a. Date (Mont) 28b. Place building  | of Injury  h, Day Year)  of Injury - At horn  ng, etc. (Specify)   | 28b. Time of Injury  me, farm, stre                            | 28c. Injun Worl M 1 1                                     | v at k? Yes 2 N   | 28d.                         | performed performed to the control of the control o | d? de 1 □ Cher injury occurred et and Number State) | (Specify)   | Route Number,                            |   |
| DIVISION OF VITAL  | the Hospital or Attending Physician: in 24 hours elter death he Funerel Director: After this certifica pietely filled in by the funeral director,                    | Certification: To         | examiner?  1 Yes 2 No  27. Manner of Death  1 Autural 5 Pendin investig  2 Accident investig  4 Homicide 6 Could determ  29a. Certifier   | Hospital: 1 1 28a. Date of (Mont) gation not be interested 28e. Place   | of Injury h, Day Year) of Injury - At horng, etc. (Specify) best of my knownsis of examinati                 | 28b. Time of Injury  me, farm, stre                            | 28c. Injun Worl M 1 1                                     | v at k? Yes 2 N   | 28d.                         | performed performed to the control of the control o | d? de 1 □ Cher injury occurred et and Number State) | (Specify)   | Route Number,                            |   |
| DIVISION OF VITAL  | hysician<br>this certifi<br>al director  | ဥ                         | examiner?  1 Yes 2 No  27. Manner of Death  1 Selatural 5 Pendin investig  2 Accident 3 Suicide 6 Could determ  29a. Certifier Check only 2 Medical   | Hospital: 1 1 28a. Date (Mont grant on the building Physician: To the Examiner: On the band mann  | of Injury h, Day Year) of Injury - At horng, etc. (Specify) best of my knownsis of examinati                 | 28b. Time of Injury  me, farm, stre                            | 28c. Injun Worl M 1 1                                     | er: Nur. y at k? Yes 2 \[ \] N ne, date and pinion, death | 28d.                         | performed performed performed performed performed performed performance perfor | d? de 1 □ Cher injury occurred et and Number State) | ath? Yes 2 (Specify)  or Rural her as sta d due to to (Month, D | Route Number, ted. he cause(s) ay, Year) |   |
| DIVISION OF VITAL  | To the Hospital or Attending Physician: within 24 hours elfer death To the Funerel Director: After this certifica completely filled in by the funeral director,      | Certification: To         | examiner?  1 Yes No  27. Manner of Death  1 Alatural 5 Pendin investig  2 Accident investig  4 Homicide 6 Could determ  29a. Certifier (Check only one) 2 Medical   | Hospital: 1 1 28a. Date (Mont grant on the building Physician: To the Examiner: On the band mann  | of Injury h, Day Year) of Injury - At horng, etc. (Specify) best of my knownsis of examinati                 | 28b. Time of Injury  me, farm, stre                            | 28c. Injun World M 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2  | er: Nur. y at k? Yes 2 \[ \] N ne, date and pinion, death | 28d.                         | performed perfor | de 1  | ath? Yes 2 (Specify)  or Rural her as sta d due to to (Month, D | Route Number, ted. the cause(s)          |   |
| DIVISION OF VIEW   | To the Hospital or Attending Physician: within 24 hours eiter death. To the Funerel Director: After this certified completely filled in by the funeral director, t   | Certification: To         | examiner?  1 Yes No  27. Manner of Death  1 Alatural 5 Pendin investig  2 Accident investig  4 Homicide 6 Could determ  29a. Certifier (Check only one) 2 Medical   | Hospital: 1 1 28a. Date of (Mont) gation not be ined 28e. Place building Physician: To the Examiner: On the be and mann                       | of Injury h, Day Year) of Injury - At horng, etc. (Specify) best of my knownsis of examinati                 | 28b. Time of Injury me, farm, stre                             | 28c. Injuny Word M 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2  | y at k? Yes 2 Nume, date and pinion, death                | 28d.                         | performed perfor | de 1  | ath? Yes 2 (Specify)  or Rural her as sta d due to to (Month, D | Route Number, ted. he cause(s) ay, Year) |   |
| DIVISION OF VICE   | To the Puspital or Attending Physician: within 24 hours sleft edeal. To the Funeral Director: After this certifical completely filled in by the funeral director, to | Medical Certification; To | examiner?  1 Yes 2 No  27. Manner of Death  1 Selatural 5 Pendin investig  2 Accident 3 Suicide 4 Homicide 6 Could determ  29a. Certifier (Check only one) 2 Medical  29b. Signature and title of certifier | Hospital: 1 1 28a. Date of (Mont) gation not be ined 28e. Place building Physician: To the Examiner: On the band mann of the completed cause. | of Injury h, Day Year)  of Injury - At hor ng, etc. (Specify)  best of my know asis of examinati ner stated. | 28b. Time of Injury me, farm, stra wledge, death on and/or inv | 28c. Injun World  M 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | y at k? Yes 2 Nume, date and pinion, death                | 28d.                         | performed perfor | de 1  | ath? Yes 2 (Specify)  or Rural her as sta d due to to (Month, D | Route Number, ted. he cause(s) ay, Year) |   |

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manylend Appartment of Health and Mental Hydiene

|                     |  |                               | Amend Item 24a per verbaling 7676,02914708<br>Certifica  | ate of                             | Death  |   | eg. No.                   | )8                              | 04268   |
|---------------------|--|-------------------------------|--|------------------------------------|--|---|---------------------------|---------------------------------|---|
|                     | Dhysia   | ion                           | Decedent's Nama (First, Middla, Last)  |                                    |  | 2. Data of Deat<br>Month                    | h<br>Day                  | Yaar                            | 3. Tima of Death  |
|                     | Physic<br>/Meďi  |                               | Helen J. Henry   |                                    |  | January                                     |                           | )8                              | 1:20 PM   |
| war.                | Exami  | ner                           | 4a Facility Name (If not institution, giva street end number)  North Hampton Manor   |                                    | 4b. City, Town, or Lo<br>Frederick                       |   | 4c. County of             |                                 |   |
| 3                   | Funeral<br>Director  |                               | 285-16-7600 1□ M 2∏ F 88 Yrs. Month  | dar 1 Yaar<br>ns Days              | If Under 24 Hrs.<br>Hours Min.                           | 8. Date of Birth<br>(Month, Dey,<br>NOV 24, | Yeer)<br>1919             | 9. Birthpl<br>Count<br>Ohio     | laca (State or Foreign<br>try)<br>O                                     |
|                     | land w   |                               | Usual Rasidance of Decedant  10a. Stata 10b. County 10c. City, Town or Location  |                                    |  |   |                           | 10                              | 0d. Insida City Limits  |
|                     | he Mery<br>28a-f ah<br>potition  | ector                         | MD Frederick Frederic  |                                    |  |   |                           |                                 | 1 ☐ Yas 2½ No   |
|                     | 23a or   | 'al Dir                       | 10e. Street and Number<br>200 E. 16th Street   | Zip Coda                           | 21701  | 11  | og. Citizan of W<br>US    |                                 | tryr  |
| 020                 | is 1 end 2 should be filed within 72 hours after death with the Meryland of Health end Mantel Hygiena. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantiner must be notified at | Completed by Funeral Director | 1 Nevar Marriad 2 Married 1 Yas 2 No   | cedant of H<br>pecify Cuba<br>2 No | dispanic Origin? (Spe<br>an, Mexican, Puarto<br>Specify: | ecify Yas or No-<br>Rican, etc.)            | Black                     | - Amarica<br>k, Whita, e<br>Whi | etc.  |
| Maryland 21215-0020 | within 72 ho<br>ina.<br>Ihan "natur<br>in Medical  | mpleted                       | Elamantary/Secondary (0-12) Collega (1-4or 5+)   | work done<br>Lusa retired          | during most of worki                                     | ing   | 16b. Kind of Bus          | sinass/Ind                      | <sup>Justry</sup> unk   |
| <b>d</b> 2          | Hygia<br>Hygia<br>ther   | ပ္ပ                           | unk unk  17. Fathar's Nama (First, Middfa, Last)   | seci                               | retary<br>18. Mothar's Nama                              | (First, Middle, N                           | Maiden Sumama             | a)                              |   |
| an                  | 2 should be filed with<br>end Mantel Hygiana<br>is marked other that<br>aumetic event, the   | To Be                         | William Francis Rodgers  |                                    |  | gnes McE                                    |                           | 1                               |   |
| ary                 | should<br>nd Man<br>merke  | -                             |  | ass (Street                        | and Number or Rure                                       |   |                           | Stata, Zip                      | Coda)   |
|                     | alth e 27 ls   |                               | William I. Henry/son 12623 We  | est Oa                             | ak Drive M   | Mt. Airy                                    | , MD 21                   | 771                             |   |
| Baltimore,          | nit. Pages 1 entmant of He ortant: If Item Injury or other.  |                               | 20a. Mathod of Disposition 1 □ Burial 2 □ Cramation 3 □ Removal from State 4 ☒ Donation 5 □ Other (Specify)  | lame of<br>r othar plac            | ca)  | Data 2                                      | 20c. Location - 0         | City or Tov                     | wn, Stata   |
| Balt                | permit. Page<br>Depertment of<br>Important: If<br>any Injury or<br>pnce.   |                               |  |                                    | omy Board<br>MD 2120.                                    |   | Baltimo                   | re S                            | treet   |
|                     | THE STREET   | П                             | 23a. Part1. Entar tha disease, or implications hat caused the death. Do not enter the mishock, or heart failure. List only one cause on each line.   |                                    |  |   | ıst,                      | 1                               | Approximata<br>Intarval Batwaan<br>Onsat and Daath                      |
|                     | Physician  |                               |  |                                    |  |   |                           | 1                               | Onsat and Daath   |
|                     | /Medical<br>Examiner   |                               | Immediata Causa (Final disaasa or condition  | W                                  | disease  |   |                           |                                 | YLALS   |
|                     |  | ē                             | Immediata Causa (Final disaasa or condition rasulting in death)  a. Due to (or as a consequance or condition)  | 1/1 to                             | 4  |   |                           |                                 | YEARS.  |
| x 68760,            | certificate be axecuted<br>ding physician and<br>isa as the burial-transit   | VMedical Examiner             | Sequantially list conditions, if any, laading to immediate cause. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in death) Lest  b. Due to (or as a consaquance of c  |                                    | <i>1</i>   |   |                           |                                 | 7 67)   |
| Box                 | d for u  | Iclar                         | Part II. Other significant conditions contributing to death but not resulting in the underlying  |                                    | en in Deet I   | 1 22h Did to                                | heada uga dan             | tribute to                      | the cause of death?   |
| P.0.                | hat tha c<br>od by the<br>datacheo   | Physician/M                   | Sick Sinw Syndisne   | j causa giv                        | an in Paπ I.   |   |                           |                                 | abiy 4 □ Unknown  |
| of Vital Records,   | The lew requiras that tha death cert<br>ete has been signed by the attandin<br>page 2 should be datached for usa   | Completed by                  |  |                                    |  | 24a. Was ar<br>perform                      |                           | con                             | era autopsy findings<br>illabla prior to<br>nplation of causa<br>deeth? |
| Œ.                  | The lew<br>ete has<br>page 2 :   | Š                             |  |                                    |  | 1 □ Ya                                      | s 2 <b>X</b> No           | 1 🗆                             | Yes 21 No   |
| ita<br>I            | stan:<br>artifica<br>octor,  | Be (                          | 25. Was casa rafarred to medical axaminar?   |                                    | 26. Place of Death                                       | (Check only on                              | a)                        |                                 |   |
| <del>_</del>        | Physician:<br>this certific<br>rel director,   | 2                             | 1 ☐ Yas 2 DNo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ [  |                                    | 4 Mursing Hor  | ma 5□ Reside                                |                           |                                 | )   |
| n C                 | After funer  | ë                             | 27. Mannar of Death  1 Stratural 5 Pending (Month, Dey Year)  1 Injury | 28c. Injun<br>Worl                 | yat<br>k?<br>Yas 2 □ No                                  | 28d. Describe ho                            | w injury occurre          | М                               |   |
| Division            | i or Attending<br>after death.<br>Director: After<br>I in by the fune  | Certification:                | 2 Accident invastigation 3 Suicida 6 Could not be datarmined 28e. Plece of Injury - At homa, farm, straet, factor building, etc. (Specify)   |                                    |  | 28f. Location (Str<br>City or Town          | aat and Numbe<br>, State) | r or Rural                      | Route Number,   |
|                     | To the Hospital or Attending Physician: The k within 24 butus after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page  | lical                         | 29a. Cartifier (Check only one)  1 Cartifying Physician: To the basis of examination and/or investigation and manner stated.   | on, in my o                        | pinion, death occurre                                    | ed at the tima, da                          | ita and place, a          | nd due to                       | ated.<br>the ceuse(s)   |
|                     | Veithir<br>To th   | M                             | 29b. Signatura and Many dentitier  | 9c. Licans                         | a number   | 29  | d. Date signad            | (Month, E                       | Day, Year)  |
|                     |  |                               |  | 1906                               | WV3  |   | 1410                      |                                 |   |
| (                   | 0  |                               | 30. Nama and addrass of person who complated causa of death (Item 23e) (Type, Pint)  1. A VE GW TO LATIUM, TO 196 TO DELLE  31. Data filed (Month, Day, Year)  FEB 1 4 2008  | 16, P.                             | reseuce,   | , Mb -                                      | N703                      |                                 |   |
|                     | Sta<br>Registr   | te<br>ar                      | FEB 1 4 2008   |                                    |  |   |                           |                                 |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NANCY R. HURST FEBRUARY 8, 2008 12:41 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year Months Days 5. Social Security Number If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) 11/30/1921 Hours 1 M 2 KF 217-12-9396 86 MARYLAND Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits 28a-f show notifled at MD 1 ☐ Yes 2 No BALTIMORE Director PARKTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 17709 BACKBONE RD 21120 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify:WHITE þ 3 ☐ Widowed 4 Divorced Year or Dates: other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) 2 YRS should be filed withind Mental Hygiene. MEAT PURVEYOR MEAT PURVEYOR is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RUSSELL JONES GOLDIE of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANET BARRON (FRIEND) 15427 FALLS RD SPARKS, MD. 21152. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY 02/11/08 BALTO CITY, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility HENRY 16924 W. JENKI YORK RD INS & SONS CO. MONKTON, MD. 21111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resciratory arrest, shock, or heart failure. List only one cause on each live. Approximate Interval Betweer Onset and Deat Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a o Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a c Examine certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical as aftending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 5 ☐ Other (specify) 4□Pregnant at time of death O the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1∐ Yes Division or Vital 25. Was case referred to medical examiner?

12 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury (Month, Day) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide Plue of Jigury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Nu-City or Town, State) 4 Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

1

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type,

Year)

Day,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 05:28 M JOHNSON FEBRUARY EUGENE 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL BALTIMORE HUPKINS CITY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 04/22/1944 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 63 Director 220-42-4276 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Jefferson WV 1 ☐ Yes 2 No Harpers Ferry Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 90 Maryland View Drive 25425 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor of Economics Shepherd University 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gustav Viola Marie St. Martin Eugene Johnson ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Clem Johnson, Wife 90 Maryland View Drive, Harpers Ferry, WV 25425 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 Removal from State Elmwood Cemetery 02/16/08 Shepherdstown, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune M01113 22. Name and Address of Facility Melvin T Strider Co, Inc. P.O. Box 388, Charles Town, WV 25414 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** HEPATIC FULMINANT WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ACUTE WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine physician and The law requires that the death certificate be executed the bunal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural (Month, Day Year) 1 Nature... 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death completely filled in by the 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I Time Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier , MEDICAL POCTOR RES-000 FEBRUARY 12. 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KIA AFSHAR, JOHNS STREET, BALTIMOLE, MANYLIND HOSPITAL, 600 NORTH WOLFE HOPKINS 32. Registrar's Signature 31. Date filed (Month, Day, State S. Salan 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Feb. 2, 2008 Lessie Johnson 5:38a. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 X F 46 578-92-9925 Dec. 13, 1961 Wash., D.C. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 No Prince Georges Capital Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4315 Shell Street 20743 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐xNo Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abraham Dickey Lessie Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lessie Dickey(Mother) 4315 Shell St., Capital Heights, Md. 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cemetery 2-15-08 Suitland, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis Funeral Home Ifullio Bll N.Patrick St., Alexandria, VA. 22314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence 424 hrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ▷ No 24a Was an autopsy 1∏ Yes 26. Place of Death (Check only one) Hospital:

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

MD.

**Funeral** 

Director

show r 28a-f show notified at

"natural", or items 23a or edical Examiner must be

the Medical

Hygiene.

permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, the

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Examine Physician/Medical ð

and burial-trar physician the as attending p for use as the þ peen has page 2 certificate this

that the death certificate be executed

or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Completed Be P Certification: After death. Director: To the ..
within 24 hours ..
To the Funeral Direction ...
Letely filled in ...

State Registrar

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

29c. License number 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

D0033512

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIVINGSTONRd: FT. Washington, MD

31. Date filed (Month, Day, Year) 2008 FEB



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            |  |                   | State of Maryland / De  | epartment of Hea<br>Certificate of Dea   |  | 2009  | 01,272                                   |
|----------------------------|--|-------------------|---|--|--|---|--|
|                            |  |                   | Registrar  1. Decedent's Name (First, Middle, Last)   | Jertinicate of Det   | 2. Date of D   | eath  | 3. Time of Death                         |
|                            | Physici<br>/Medic  |                   | Catherine Jane Jac  | kson   | Feb. 1   | 2, 2008 Year  | 8:59 PM                                  |
|                            | Examin   |                   | 4a. Facility Name (If not institution, give street and number) 1776 Wye Dr.   | 4b. City, Town, or Loca<br>Pasadena  |  | 4c. County of Death<br>Anne Arur                            | nde1                                     |
|                            | Funeral  |                   | 5. Social Security Number 6. Sex 7. Age (In yrs. last birth 192–32–7463 1 M 2 📈 95 Y  |  | Under 24 Hrs. 8. Date of Bi<br>lours Min. (Month, D                  | ay, Year) Cour  | lace (State or Foreign<br>try)           |
| _ 6                        | Director   |                   | Usual Residence of Decedent   |  | Aug.   | 12, 1912 Per  | nsylvania                                |
|                            | aryian<br>show<br>d at   | 7                 | 10a. State 10b. County 10c. City, Town  |  | · · · I · · ·  | 1   | 0d. Inside City Limits<br>1 ☐ Yes 2 🛣 No |
|                            | the M<br>28a-f<br>notifie  | Funeral Director  | Md. Anne Arundel  | 10f. Zip Code  | sadena   | 10g. Citizen of What Cour                                   |  |
|                            | h with<br>3a or<br>st be   | al Di             | 1776 Wye Dr.  | 21122  |  | USA   |  |
|                            | r deat   | nner              | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?  |  | nic Origin? (Specify Yes or N<br>Nexican, Puerto Rican, etc.)        |   |  |
| 36                         | rs afte<br>I", or if<br>xamin  | by Fi             | 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:   | 1 ☐ Yes 2 🗖 No Sp  | pecify:  | Specify: W  | ite                                      |
| 9                          | 72 hou<br>natura<br>lical E  | sted              | 15. Decedent's Education 16a. D   | Decedent's Usual Occupation  | T<br>ng most of working  | 16b. Kind of Business/Ind                                   | dustry                                   |
| 121                        | filed within 72 hours after death with the Maryland<br>Hygiene.<br>uther than "natural"; or items 23a or 28a-f show<br>ent, the Medical Examiner must be notified at   | Completed by      | Flementary/Secondary (U-12)   College (1-4or 5+)  | Give kind of work done during<br>life. DO NOT use retired)<br>Teacher  | g most of working  | Public So   | hool                                     |
| Maryland 21215-0036        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Be Co             | 17. Father's Name (First, Middle, Last)   |  | Mother's Name (First, Middle   |   |  |
| ylan                       | should be<br>ind Mental<br>marked o  | To B              | George L. McCullough  |  |  | . Shunk   |  |
| Mar                        | 12 sho<br>h and<br>7 is ma<br>trauma   |                   |   |  | Number or Rural Route Num  |   | Code)                                    |
| ъ́.                        | s 1 and<br>f Health<br>tem 27<br>other t   |                   | 20a. Method of Disposition 20b. Place of D  | 770 Wye DT Po<br>Disposition (Name of<br>g crematory or other place)   | asadena, Md.   | 20c. Location - City or To                                  | wn, State                                |
| <u>E</u>                   | Pages<br>nent of I<br>ant: If ite<br>ury or o  |                   | 1 2 Burial 2 Cremation 3 Removal from State   | ton Cemetery   | 2/16/08  | Emlenton, P   | 2a .                                     |
| Baltimore,                 | permit. Departm Importal any inju  |                   | 21. Signature of Funeral Service (1) 19 e   | 22. Name and Address of  | Facility Stallings   | Funeral Home  | PA                                       |
|                            | 0 D = 6 0  |                   | 23a Part1 Enter the disease or complications that caused the death. Do no   |  | n Rd, Pasaden  |   | Approximate                              |
|                            | Physician  |                   | 23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or carefully in a second state of the cause of the ca | Pun O O  | to luve  |   | Interval Between<br>Onset and Death      |
|                            | /Medical   |                   | disease or condition resulting in death)  a. Due to (or as a consequence of   | ): in the state of | ) a d = 1  |   |  |
|                            | Examiner   | <u>,</u>          | Sequentially list conditions,   | use ku   | - Jones  | 4re   |  |
| Τ                          | uted<br>d<br>ansit   | Examiner          | cause. Enter Underlying Cause (Disease or injury  | ,-   |  |   |  |
| 0                          | cate be executed<br>ohysician and<br>the burial-transit  | Exa               | resulting in death) Last C. Due to (or as a consequence of  | ):   |  | -   |  |
| ,0928                      | icate be<br>physici<br>s the bu  | dical             | d   |  |  |   |  |
| Box 6                      | The law requires that the death certific<br>tte has been signed by the attending p<br>bage 2 should be detached for use as   | Physician/Medical | IF FEMALE: 23c. If yes, outcome pf pregnancy  |  |  | 23d. Date of delive   | ery                                      |
|                            | e death<br>ne atte<br>ed for   | sicla             | in the past 12 months?  1 Yes 2 Mo  1 Live Dirth 2 Fetal death 4 Pregnant at time of death  | 3 ☐Ectopic pregnancy<br>5 ☐ Other (specify)  |  | Month   | Day Year                                 |
| P.0                        | hat the<br>d by tl<br>detach   |                   | 9☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in t  | the underlying cause given in  | Part I 23e. Did  | tobacco use contribute to the                               | ne cause of death?                       |
| Division or Vital Records, | w requires that<br>s been signed is<br>should be det   | d by              | luftestusion  | A.   |  | Yes 2 No 3 Prob   | . /                                      |
| SCO                        | law rec<br>as beer<br>2 shou   | plete             | Aneuna of churz   | di segne   | 24a. Wa  | s an 24b. Were auto   | psy findings available                   |
| Ä                          |  | Completed         | Oseo Altry h's  | > .  |  | opsy<br>formed? prior to co<br>death?<br>2 ☑ No 1 ☐ Yes     | npletion of cause of                     |
| Vita                       | sician:<br>certific<br>rector,   | Be                | 25. Was case referred to medical examiner?  | Othor  | . Place of Death (Check only   | 4   |  |
| 0                          | g Physer this eral di  | ٦.<br>ا           | 1 Yes 2 No Ospital: 1 Inpatient 2 ER/Outp  27. Manner of Death 28a. Date of Injury 28b. Til  1 Mehrel 5 Pending (Month, Day Year) Inj   | me of 28c. Injury at   | 4 ☐ Nursing Home 5 ☐ Res<br>28d. Describe                            | sidence 6 Other (Specif                                     | y)                                       |
| sior                       | ending F<br>sath.<br>or: After<br>the funera   | atio              | 2 Accident investigation  | M 1 ☐ Yes  | 2 No   |   |  |
| <u>S</u>                   | or Attendafter death<br>Director:<br>in by the   | Certification:    | 3 ☐ Suicide 4 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)   | n, street, factory, office   |  | (Street and Number or Rura<br>own, State)                   | I Route Number,                          |
|                            | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page  | edical Co         | 29a. Certifier (Check only one)  1  | death occurred at the time, d  | date and place, and due to the condition, death occurred at the time | e cause(s) and manner as s<br>e, date and place, and due to | tated. the cause(s)                      |
|                            | To the within 2 To the comple  | Med               | one) and manner stated.  29b. Signature and title of certifier (200)  | 29c. License nun   |  | 29d. Date signed (Month,                                    | Day, Year)                               |
|                            | /  |                   | 1 Clary   | D 3/   | 1322   | 02/13/2   | 008-                                     |
|                            | 19   |                   |   | ype, Print) OUNTALN  | ROAD, DAS  | 02/13/2<br>ADEAA, AU  | ) 2//22                                  |
| 1                          | Sta<br>Registr   |                   | 31. Date filed (Month, Day, Year)  See 32. Registrar's Signature  FEB 1 4 2008  | suff)  |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death KEEGIN Month Year **Physician** 2 reto M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7810 Clark Rd. C80 Anne, Arundel 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 M 2□F Months Days Hours Min. Director 30 1935 Washington DC 579-46-5196 April Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits пs 23a or 28a-f show must be notified at 1 ☐Yes 2 No Director Maryland Anne Arundel Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 7810 Clark Rd., C80 20794 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yos 2 □ No If Yes, Give Year or Dates: 55-59 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√∑ No Specify Specify: þ White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) perunt. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumate. Elementary/Secondary (0-12) College (1-4or 5+) Mechanic/Welder Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Archibald C. Keegin Maria Barbot 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leona A. Keegin- wife 7810 Clark Rd., C80, Jessup, MD 20794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Feb. 16,2008 Caronsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, INC. A01234 7250 Washington Blvd., Elkridge, MD, 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 142 /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the buriai-transii Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) Manner of Death 28d. Describe how injury occurred Certification: Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation To the Hospital or Attency within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

10

State Registrar M(C(FAEL ),
31. Date filed (Month, Day, Year)

DEFENSE GETTWAY ANNOUS

30 Name end address of person who complete cause of death (Item 23a) (Type, Print)

2008

NA W 441

32. Refistrar's Signature

|  |                   |   | Please                             | Type or Prir  |   |  |   |  | -                     |                  | •                                     |   |             |
|--|-------------------|---|------------------------------------|---|---|--|---|--|-----------------------|------------------|---------------------------------------|---|-------------|
|  |                   | For   |                                    | State of Ma   | aryland                                 |  |   |  | Mental Hy             | /gien            | e <sub>2</sub> n n c                  | 042   | 71.         |
|  |                   | 1 - State<br>Registrar  | (F) . 14' . H                      |   |   | Cer  | tificate of   | Death  |                       | Reg. N           | 10.4 UUC                              |   |             |
| Physici  | an                | Decedent's Nam  |                                    | .ast)<br>REGINA RAY                                 | VE KE                                   | יכפדו  | DINC  |  | 2. Date of D<br>Month | _ D              | ay Year                               | 3. Time of I                                |             |
| /Medic<br>Examin   |                   | 4a. Facility Name (   |                                    | ive street and number)                              | IE KE                                   | оовы   |   | or Location of Deat                              | FEB.                  | 10               | , 2008<br>lc. County of Dea           | 9:48  | Α           |
|  |                   | 316 MAI   | N ST.,                             | APT. 4  |   |  | NEW WIN   | NDSOR  |                       |                  | CARROLI                               | J   |             |
| Funeral  |                   | 5. Social Security N<br>212-68-   |                                    | Sex 7. Ag-<br>1 ☐ M 2 🔀 F                           | e (In yrs. las                          | t birthday) _<br>Yrs.  | If Under 1 Year<br>Months Days                            | If Under 24 Hrs.<br>Hours Min.                   | (Month, D             | ay, Yea          | (r)   C                               | thplace (State or ountry)                   | Foreign     |
| Director   |                   | Usual Residence of  |                                    | - 11  | 5.5                                     | 113.   |   |  | 1/28/                 | 195              | 5 PEN                                 | NSYLVA                                      | NIA         |
| nyland<br>how<br>Lat   | _                 | 10a. State  | 10b. County                        |   | 10c. City,                              | Town or Loc  | ation   |  |                       |                  |                                       | 10d. Inside City                            |             |
| ne Ma<br>8a-f s  | Director          | MD  | CARROI                             | L   | NEW                                     | WINI   | 1   |  |                       |                  |                                       | 1 🕅 Yes                                     | 2 No        |
| with the   | Dire              | 10e. Street and Nu  |                                    | A Dom. 4  |   |  | 10f. Zip Code   | 7.0  |                       |                  | Citizen of What C                     | ountry?                                     |             |
| 72 hours after death with the Maryland<br>natural", or items 23a or 28a-f show<br>alcal Examiner must be notified at   | Funeral           | 11. Marital Status  | IN 51.                             | APT. 4  | Ever in U.S.                            | 13. W  | 217 /as Decedent of H                                     | / O<br>dispanic Origin? (S<br>an, Mexican, Puerl | pecify Yes or N       |                  | JSA<br>14. Race - Ame                 | erican Indian,                              |             |
| after or iter  | Fur               |   | ried 2□ Married                    | Armed Forces?<br>1 ☐ Yes 2 🔯 N<br>If Yes, Give      | No                                      |  | Yes, specify Cuba<br>☐ Yes 2 X No                         |  | o Rican, etc.)        |                  | Black, Whi                            |   |             |
| ural",   | d by              | 3 Widowed   |                                    | Year or Dates:                                      |   |  |   |  |                       |                  | Specify: W]                           |   |             |
| n 72 h<br>"nati<br>edica   | lete              |   | 15. Decedent's cify only highest g | rade completed)                                     |   | 16a. Decede<br>(Give k   | ent's Usual Occup<br>ind of work done<br>O NOT use retire | oation<br>during most of wor<br>d)               | king                  | 16b.             | Kind of Business                      | /Industry                                   |             |
| d withi<br>giene.<br>r than  | Completed         | Elementary/Second 12  | indary (0-12)                      | College (1-4or 5                                    | +)                                      |  | USEWIF  |  |                       | но               | ME MAKI                               | ER  |             |
| al Hyg   | Be C              | 17. Father's Name   |                                    |   |   |  |   | 18. Mother's Nar                                 |                       |                  | · · · · · · · · · · · · · · · · · · · |   |             |
| ould build b | 입                 |   |                                    | NALD O. H   |   |  |   |  |                       |                  | TH COOI                               |   |             |
| d 2 sh<br>th and<br>7 is m<br>traum  |                   | JOYCE A   |                                    | (Type. Print)DAUG                                   | HTER                                    |  |   | and Number or Ru                                 | P . 1                 | ( ) <sub>-</sub> |                                       |   |             |
| tem 2  |                   | 20a. Method of Disp   | -                                  | EDICTIAG  | 20b. Plac                               | e of Dispos  | ition (Name of  | r.,APT.  | Date Do               |                  | Location - City or                    |   | JR, ML      |
| Pages<br>ient of<br>nt: If i   |                   |   | ☐ Cremation 3<br>5 ☐ Other (Spec   | Removal from State                                  |   |  | atory or other plac<br>EMETER                             | · i  | 4/08                  | HA               | MPSTEAL                               | O - MD                                      |             |
| permit. Pages 1 and 2 should be filed within 72 ho<br>Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natur<br>any injury or other traumatic event, the Medical.<br>once.  |                   | 21. Signature of  |                                    |   | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |  |   | ess of FacilityFL                                |                       |                  |                                       |   | 'A          |
| 8 8 E 8 6  |                   | 15  | <i>Y</i>                           |   |   | 25   | 4 E. MA   | AIN ST.  | , WEST                | MIN              | STER, M                               | 4D 2115                                     | 7           |
|  |                   |   |                                    | mplications that caused<br>ly one cause on each lir |   |  |   |  |                       |                  |                                       | Approximate<br>Interval Betw<br>Onset and D | een<br>eath |
| Physician /Medical   |                   | Immediate Cause disease or condition resulting in death)                                | rinai<br>n                         | a<br>Due to (or as                                  |   |  | S WITH  | RESPRAN  | bry Ar                | RES              | ST                                    | Minute                                      |             |
| Examiner   |                   |   |                                    |   | -                                       | 3 Une  | desard  | IRA  |                       |                  |                                       | 4-ears                                      | ,           |
| 70 #   | ner               | Sequentially list co<br>if any, leading to in<br>cause. Enter Unde<br>Cause (Disease or | nditions,<br>nmediate<br>erlying   | b<br>Due to (or as                                  |   | -  | 000,000   |  |                       |                  |                                       | J   |             |
| executed<br>in and<br>ial-transit  | Examiner          | Cause (Disease or<br>that initiated events<br>resulting in death) I                     | S                                  | c   |   | 0  |   |  |                       |                  |                                       |   |             |
| be icia  |                   | roodining in doddiny i  |                                    | Due to (or as                                       | a consequer                             | nce of):   |   |  |                       |                  |                                       |   |             |
| ficate<br>phys<br>s the  | Physician/Medical |   |                                    | d   |   |  |   |  |                       |                  |                                       |   |             |
| h certi<br>ending<br>use a   | II/M              | IF FEMALE:<br>23b. Was deceden  | t pregnant                         | 23c. If yes, outcome<br>1 ☐ Live birth              |   |  |   |  |                       |                  | 23d. Date of de                       | livery                                      |             |
| e deat   | sicia             | in the past 12<br>1 ☐ Yes 2.  | No                                 | 4□Pregnant at                                       |   |  | Ectopic pregnancy<br>Other <i>(sp</i> ec <i>ify)</i>      | у  |                       |                  | Month                                 | Day Y                                       | ear         |
| hat the<br>d by ti<br>letach   | Phy               | 9 ☐ Unknown   |                                    | contributing to death bu                            | ıt not roculti                          | ng in the une  | dorlying course give                                      | on in Port I                                     | 220 Did               | tobooo           | use contribute to                     | o the course of de                          | ath 2       |
| signe<br>d be d  | þ                 | ( OP  |                                    | maker   | at not resulti                          | ng in the unc  | denying cause giv   | en in Fan I.                                     |                       |                  | ,                                     | othe cause of de<br>robably 4 ∐U            |             |
| w requ   | letec             | GW.   | munta                              | TIONE.  |   | -  |   |  | 24a. Was              |                  | - 7                                   | utopsy findings a                           |             |
| The lar  | Completed         | (02   | 2000                               | also de   | 1-000-0                                 |  |   |  | auto                  |                  | prior to                              | completion of ca                            |             |
| ian:<br>rtifical   | Be C              | 25. Was case refer  | red to medical                     | or try w  | hears                                   | <u>ا</u>   |   | 26. Place of Dea                                 |                       |                  | lo 1 □Yes                             | s 2□No                                      |             |
| hysic<br>this ce   | ToE               | examiner?<br>1 ☐ Yes 2  |                                    | Hospital: 1 ☐ Inpatie                               | nt 2□EF                                 |  |   | 4 ☐ Nursing H                                    | ome 5 Res             | idence           | 6 □Other (Spe                         | ecify)                                      |             |
| ling P   |                   | 27. Manner of Deat<br>1 Natural   | 5 Pending                          | 28a. Date of Injui<br>(Month, Day                   |   | Bb. Time of<br>Injury  | 28c. Injur<br>Wor   |  | 28d. Describe         | how inj          | ury occurred                          |   |             |
| Attenc<br>death<br>ctor:<br>y the  | licat             | 2 ☐ Accident<br>3 ☐ Suicide   | investigation 6 ☐ Could not        | be Riese of inju                                    | ırv - At home                           | e. farm. stree   |   | Yes 2 □ No                                       | 28f Location          | (Street          | and Number or R                       | ural Route Numb                             | er          |
| To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the   | Certification:    | 4 ☐ Homicide  | determine                          | building, etc                                       | . (Specify)                             | ,  | -,,   |  | City or To            | wn, Sta          | ite)                                  | urai rioute numb                            | CI,         |
| lospita<br>hours<br>unera  |                   | 29a. Certifier<br>(Check only   | 12 Certifying F                    | Physician: To the best of aminer: On the basis of   | of my knowle                            | edge, death  | occurred at the tir                                       | me, date and place                               | , and due to the      | cause            | (s) and manner a                      | s stated.                                   |             |
| the H<br>hin 24<br>the F   | Medical           | one)  |                                    | and manner sta                                      | ited.                                   |  |   |  | irred at the time     |                  |                                       |   |             |
| Viti<br>Cor  | -                 | 29b. Signature and  | title of certifier                 | 000   | e.,                                     |  | 29c. Licens   |  |                       |                  | ate signed (Moni                      | th, Day, Year)                              |             |
|  | -                 | 30 Name and addr  | haven y                            | o completed cause of de                             | 900 (ltom 2)                            | M) (Type B   | rint)   | 11725  |                       |                  | 411/08                                |   |             |
|  |                   | Sharon  |                                    | 10NG1   | 212                                     | - WA-  | Straton   | Height   | Medi                  | ca O             | lenke                                 | Westn                                       | neutos      |
| Sta  |                   | 31. Date filed (Mon   | nth, Day, Year)                    | 32. Registra  | ar's Signatur                           | e A coall  | 1   |  | , ,,,,,,,             |                  | F 61 6 1 1 1 1                        | Moz   | 1157        |
| Registr  | ar                | FFF   | 3 1 4 200                          |   | of the state                            | A STATE OF THE STA | 9"  |  |                       |                  |                                       |   |             |

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1 tem 20b per 1h 9876 2-14-08 vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9 4:08P M ANN FEBRUARY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROLAND PARK PLACE BALTIMORE N/A 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min. Months Days (Month, Day, Year) 04/02/1919 1 □ M 2 🕱 F 219-16-7854 88 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 830 W. 40TH STREET, APT. #408 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No WHITE Specify 3 X Widowed 4 □ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "ratuu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELKAN MYERS COHN MARCELLA ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2208 KEN OAK ROAD, BALTIMORE, MD LEON KATZ / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 02/<del>11/</del>2008 BALTIMORE, MD 5 ☐ Other (Specify) ignature f Fu 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 tions that cau d the cause on each line. 23a. Part1. Enter the disease, or complice shock, or heart failure. List only in leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final lympHcmA STATIC Me **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-tra Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 2 No 1∐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 10, 2008 In mo D35102 Juany 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANTES Street Palfimore many land Norn DONM.D. 5901 State Registrar

フ ス

Examiner Division or Vital Records, P.O. Box 68760. the attending signed by After this certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ont: If Item 27 is marked other than "natural", or Items 23a or 28a-f show

Saltimore, Maryland 21215-0036

physician and s the buriel-trans as for use page 2 should be

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Court Rd, Rondallstown, MD 21133 5401 Old

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- State Amend #1,2, perMD, g876, 2/14/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Feb. 5, 2008** Hogth 05/1832 **Physician** Charles Luby Charles Edward Luby /Medical 20:20 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2/18/1932 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 → M 2 □ F 75 220-26-6183 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at annex. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes > No Director Montgomery Germantown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20874 USA 18003 Matney Rd. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Yard Foreman Lumber Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Natalie Gray Arthur M. Luby, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18003 Matney Rd., Germantown, MD 20874 Beulah Luby/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bushy Park Cemetery 2/11/2008 Cooksville, MD 21. Signature of Funeral Service Licenses Burrier Advertir Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 3a. Pa M. Enter the disease, or complications that cassed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MINUTES ediate Cause (Final Myocardial Infarction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** years Cardiovascular Disease Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed years Diabetes/Hypertension that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 1 Tyes 2 □ No 9 DUnknown should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1∐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2X ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural To the right after death.

Within 24 hours after death.

To the Funeral Director: Af 5 Pending 1 TYes 2 TNo investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mil 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael G. Cetta, M.D. 9901 Medical Center Dr., Rockville, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar 2008 FEB 4

DHMH 17 Rev 1/2001

| 08-01039    |
|-------------|
| Leroy Lucas |

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| roy L                      | ucas   |                  | State of Maryland / Department of 1- For State Certificate of Registrar  |  |   | 200                               | 8 0427   |
|----------------------------|--|------------------|--|--|---|-----------------------------------|--|
| edica                      | Physici<br>al Exam   |                  | Decedent's Name (First, Middle,Last)   |  | 2. Date of Death<br>Month<br>February 5 |                                   | 3. Time of Death<br>1506 hrs                   |
|                            |  |                  |  | o. City, Town, or Location of Death<br>District Heights          |   | 4c. County of Death Prince George | s  |
|                            | Funeral  |                  | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  | •  | 8. Date of Birth                        | (MM/DD/YYYY) 9. Birth             | nplace (State or Washingto:                    |
|                            | Director   |                  | 579-78-5244   1X M 2 F   53 Yrs.   | World's Days Hours Will  |   | 4, 1955 Cou                       | ntry DC  |
|                            | w any  |                  | 10a. State 10b. County 10c. City, Town or Location   |  |   |                                   | 10d. Inside City Limits 1 X Yes 2 No           |
|                            | ie Maryland<br>or 28a-f show any<br>fied at once.  | ctor             | MD Prince George's Forestvill  10e. Street and Number  | e<br>10f. Zip Code   | 10                                      | g. Citizen of What Coun           |  |
|                            | eath with the Maryland items 23a or 28a-f shout be notified at once.   | al Dire          | 6845 Red Maple Court   | 20747  |   | USA                               |  |
|                            | and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygerd et elem 71 is marked ofter than "natural", or items 23a or 28a-f she reamvaite event, the Medical Examiner must be notified at once trannatic event, the Medical Examiner must be notified at once | Funeral Director | 1 Never Married 2 Married Armed Forces 2 If Ye   | Decedent of Hispanic Origin? (Ss, specify Cuban, Mexican, Puerto |   | 14. Race - Americ<br>White, etc.  |  |
|                            | urs after<br>tural",<br>aminer   | þ                | lor Dates:   | Yes $2  X $ No $specify$ :<br>s Usual Occupation (Give kind of   |   | specify: Blac                     |  |
| 36                         | Pages 1 and 2 should be filed within 72 hours after<br>ment of Health and Mental Hygiens<br>tant: If tiem 27 is marked other than "natural",<br>or other traumatic event, the Medical Examiner;  | Completed        | Elementary/Secondary (0-12) College (1-4 or 5+) during mo  | st of working life. DO NOT use ret<br>tory Therapist             | ired)                                   | Hospital                          |  |
| 21215-0036                 | uld be filed withi<br>Mental Hygiene.<br>marked other th   |                  |  | 18.Mother's Nam  | e (First, Middle, M                     |                                   |  |
| 2121                       | uld be fi<br>Mental<br>marked<br>c event,  | To Be            | Herman Lucas  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing  | Mary Jo Address (Street and Number or                            |   | ber, City or Town, State,         | Zip Code)                                      |
| MD                         | and 2 shoralth and em 27 is raumatic   |                  |  | erfront Lane, T  | imberlak<br><sub>Date</sub>             | e, NC 27583                       |  |
| nore                       | Pages 1 a<br>ent of He<br>nt: If it  |                  | 1 Burial 2 Cremation 3 Removal from State crematory or other   |  |   | Alexandria,                       |  |
| Baltimore, MD              | permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum   |                  | 21. Schalare of Funda Survice Licensee 22. Na  | ame and Address of Facility Ma<br>8 Suitland Road                | rshall's                                | Funeral Ho                        | me of MD                                       |
| Ph                         | nysician   |                  | 23a. Pen Eriter the disease or complications that caused the death. Do not enter the fall i.e. List only one cause on each line.                         |  |   | •                                 | Approximate Interval<br>Between Onset and      |
|                            | Medical<br>xaminer   |                  | Imm dif te Cause (Final disease or condition resulting in death)  a. Hypertensive Atherosclerotic Cardic   |  |   |                                   | Death  |
|                            |  | Į.               | Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):  |  |   |                                   |  |
|                            |  | edical Examiner  | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):                        |  |   |                                   |  |
|                            | te be executed<br>sysician and<br>burial - transit   | al Ex            | d  |  |   | · •                               |  |
| ,60                        | certificate be executed<br>nding physician and<br>se as the burial - transi  |                  | UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy   | **   |   | 23d. Date of delivery             |  |
| Box 6876                   | eath certificate<br>attending phy<br>for use as the b  | Physician/N      | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Feto 4 Pregnant at time of death 5 Oth   | al death 3 Ectopic pregn<br>er (Specify)                         | ancy                                    | Month D                           | ay Year  |
| _•                         | the d<br>by the  | Phys             | Part II. Other significant conditions contributing to death but not resulting in the ur  | nderlying cause given in Part I.                                 | 23e. Did to                             | bacco use contribute to           | the cause of death?                            |
| s, P.O                     | w requires that the<br>as been signed by<br>should be detach   | ≦                | Cirrhosis of the liver, renal insufficiency, multiinfarct encenha  | lopathy  |   | 2 No 3 Prob                       |  |
| Division of Vital Records, | E 52   | Completed        |  |  | 24a. Was a<br>autops<br>perfor          | sy prior to comed? death?         | topsy findings available ompletion of cause of |
| al Re                      | cian: The<br>certificate<br>ector, page  | Be Co            | 25. Was case referred to medical   | 26.Place of Death (Check   | 1 Yes 2                                 | 2 No 1 ✓ Ye                       | s 2 No   |
| of Vit                     | ding Physic  1. After this c   | 은                | 1 V Yes 2 No Inpatient 2 ER/Outpatient   |  |   | Residence 6 Other                 | : Scene  |
| ion                        | ttending<br>death.<br>:tor: Af<br>y the fun  | ation            | 1 V Natural 5 Pending (Month, Day, Year) 2 Accident Investigation  | 1 Yes 2 No   |   |                                   | <u> </u>                                       |
| Divis                      | spital or Attenerous after death   | Certification:   | 3 Suicide 6 Could not be determined (Specify)  | t, factory, office building, etc.                                | 28f. Location (S<br>or Town, St         | treet and Number or Ru<br>tate)   | ral Route Number, City                         |
|                            | Hos<br>24 h<br>Fun<br>tely   |                  | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurr one) 2 Medical Examiner: On the basis of examination and/or investigati | ed at the time, date and place, an                               | d due to the cause                      | e(s) and manner as state          | ed.<br>e cause(s)                              |
|                            | To the within To the Complet   | Medical          | and manner stated.  29b. Signature and title of certifier  | 29c. License number  |   | 29d. Date signed (Mor             |  |
|                            | 7  |                  | Coma momenti, mio.   | O.C.M.E.   |   | February 6, 2008                  |  |
| 2                          | 4  |                  |  | Penn Street, Baltimore, N  | /ID 21201                               |                                   |  |
|                            | S<br>Regis   |                  | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | 15   |   |                                   |  |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 26 per verbal, g876-02/12/108/hbe ath 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 1 2008 ear **Physician** 11:03 P M Dale Hilton Lewis /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 4306 Ridge Road Baltimore County Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Annapolis, Maryland Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day **Funeral** Months 1 M 2 F 220 38 9843 65 November 28 1942 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show th and Mental Hygiene. 7 Is marked other than "natural", or Items 23a or 28a-1 shov traumatic event, <u>the Medical Examiner must be notifiled at</u> Maryland Baltimore Baltimore County 1 ☐Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21236 USA 4306 Ridge Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. þ Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Tag & label Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William M Lewis Elva Moreland ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4306 Ridge Road Baltimore, Maryland 21236 Joan M Lewis (Wife) Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 = 6 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Gardens of Faith Cem. February 4 2008 Baltimore, Maryland 22. Name and Address of Facility
Lassahn Funeral Home Inc 21. Signature of Funeral Service Licensee Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, solicity of the disease. The disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, solicity of the disease. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** KUV Wen disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examiner The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 1∐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2008 ed cause of death (Item 23a) (Type, Print)

> SEON LECTURAVEN BUD, BOUTHWOVE

Registrar

State

31. Date filed (Month, Day, Year) FEB 1 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 00 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia 8. Date of Birth (Month, Day, Year) July 19,1951 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last|birthday) **Funeral** Months Days Hours 1 □ M 2 💢 F 212-47-6175 56 Yrs. Koreá Director Usual Residence of Decedent death with the Maryland 10h. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Howard Ellicott City Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3104 Wheaton Way Apt. K 21043 Korea Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or them any injury or other traumatic event, the Modison once. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify: Specify: Asian þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cwner/Operator Deli 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Soon Ja Lee Que Jang Ahn 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yong Lee (Husband) 3104 Wheaton Way Apt. K, Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 ⊡ Cremation 3 □ Removal from State 20c. Location - City or Town, State 2/8/08 MEtro Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility **1**400053 Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd. Elkridge, MD 21075 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** INTIACIAN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner £ The law requires that the death certificate be executed Due to (or as a consequence of) physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. the 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, à 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page, this certificate 2 No or Attending Physician: ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 5 Residence 6 ☐Other (Specify) funeral dir 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation (Month, Day Year) 1 Natural Injury Division 1 ☐ Yes 2 ☐ No s after death. 2 Accident the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled Hospital 🗤 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State

Registrar

2008

FEB

SELLE S

State Registr<u>ar</u>

DHMH 17 Rev 1/2001

ORIGINAL

6121

32. Registrar's Signature

MONTROSE ROAD

ROCKVILLE MD 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

ANNA KORRAN, MO

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                     |   | ,              | 1 - For Amend It   | State of M<br>cen 24a per v  | aryland / Depa<br>e <b>rb.,g876</b>      | artment of He<br>Daile 14/08 Th                                    | ealth and N<br><b>e</b> ath                          | Mental Hyg<br>R                              | iene<br>9. No. 2008                                  | 04283  |
|---------------------|---|----------------|--|--|--|--|--|--|--|--|
|                     | Physici   | an             | 1. Decedent's Name (First, Mide  | die, Last)   |  |  |  | 2. Date of Deat<br>Month                     | h<br>Day Year  | 3. Time of Death   |
| i.:                 | /Medic  |                | Janet McDona   |  |  | г  |  | January                                      | 29, 2008   | 2:25 AM <sup>M</sup>                                     |
|                     | Examin  | er             | 4a. Facility Name (If not instituti  |  |  | 4b. City, Town, or I   |  |  | 4c. County of Death                                  |  |
| 17.                 |   |                | Gilchrist Hos  5. Social Security Number   |  | ge (In yrs. last birthday)               | Towson   | If Under 24 Hrs.                                     | 8. Date of Birth                             | Baltimore  |  |
| В                   | Funeral Director  |                | 219-30-4639  | 1□M 2MF  | 73 Yrs.                                  | Months Days  | Hours Min.   | Nov 30,                                      | Year) Cour   | place (State or Foreign<br>ntry) unk                     |
|                     |   |                | Usual Residence of Decedent  |  |  |  |  | 1101 30,                                     | 1737   |  |
|                     | nylan<br>how  |                | 10a. State 10b. Count  | У  | 10c. City, Town or Lo                    | ocation  |  |  | 1  | 10d. Inside City Limits                                  |
|                     | e Ma<br>sa-f s<br>tiffed  | cto            | MD B   | altimore   | Towso                                    | n  |  |  |  | 1 □ Yes 2√□ No   |
|                     | ith th  | Director       | 10e. Street and Number   | . O  |  | 10f. Zip Code  | 201  | 10   | Og. Citizen of What Cour                             | ntry?  |
|                     | s 23a   |                | 500 Fellowsh   | unk 12. Was Decedent   | 5  | 212  |  |  | USA  |  |
| 9036                | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral     | 11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 □ Divorce  | armed Forces armed Forces armed 1 ☐ Yes 2 🛣  | No                                       | Was Decedent of His<br>If Yes, specify Cubar<br>1 □ Yes 2ሺ No      | spanic Origin? (Sp<br>n, Mexican, Puerto<br>Specify: | pecify Yes or No-<br>po Rican, etc.)         | 14. Race - Americ<br>Black, White,<br>Specify: W     |  |
| Maryland 21215-0036 | within 72 h<br>ene.<br><b>than "natu</b><br><b>he Medicai</b>   | Completed      | 15. Decede<br>(Specify only high<br>Elementary/Secondary (0-12)<br>unk   | ent's Education nest grade completed)  College (1-4or to the control of the contr | (Give                                    | dent's Usual Occupa<br>kind of work done du<br>DO NOT use retired) | tion<br>uring most of work                           | unk  | 16b. Kind of Business/In                             | dustry unk   |
| and 2               | ild be filed<br>lental Hygi<br>ked other<br>ic event, til   | To Be Co       | 17. Father's Name (First, Middle   |  | ,  | unk  | 18. Mother's Nam                                     | ne (First, Middle, M                         | Maiden Surname)                                      | unk  |
| Mary                | and 2 shou<br>alth and N<br>27 is mar<br>er traumat   | _              | 19a. Informant's Name/Relation   |  |  | ng Address (Street ar<br>Towsontown                                |  |  | City or Town, State, Zip 21204                       | Code)  |
| Baltimore,          | Pages 1 annuary of He   |                |  | a ∃Removal from State<br>(Specify) in state  |  | osition (Name of<br>matory or other place                          | )  | Date   | 20c. Location - City or To                           | own, State   |
| Balt                | permit. Departr Importa any injt  |                | 21. Signature of Funeral Service Ronald  | S. Wade, Dir   |  | Name and Address<br>ate Anato<br>altimore,                         |  |  | Baltimore S  | treet  |
| )                   | Physician<br>/Medical<br>Examiner   | Examiner       | 23a. Part1. Enter the disease, shock, theart failure. Li Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a  | a consequence of):                       |  | 0 -  | or respiratory arre                          |  | Approximate Interval Between Onset and Death             |
| x 68760,            | certificate be executed<br>ding physician and<br>se as the burial-transit   | edical         | IF FEMALE:   | d23c. If yes, outcome  | a consequence of):                       |  |  |  |  |  |
| P.O. Box            | The law requires that the death certi<br>te has been signed by the attending<br>tage 2 should be detached for use a   | Physician/M    | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 1 ☐ Live birth<br>4 ☐ Pregnant a<br>9 ☐ Unknown  | 2 Fetal death 3                          | Ectopic pregnancy Other (specify)                                  |  |  | 23d. Date of delive                                  | ery<br>Day Year  |
|                     | w requires that<br>been signed k<br>should be det   | by             | Part II. Other significant condi   | tions contributing to death b  | out not resulting in the u               | nderlying cause giver  | n in Part I.   | 23e. Did tob                                 | acco use contribute to thes 2 □ No 3 □ Prob          | he cause of death?                                       |
| Vital Records,      |   | Completed      |  |  |  |  |  | 24a. Was ar<br>autops<br>perforn<br>1∐ Yes 2 | y prior to co<br>ned? death?                         | opsy findings available<br>mpletion of cause of<br>2□ No |
| <u> </u>            | ician: Th<br>certificate<br>ector, pag  | Be             | 25. Was case referred to medic examiner?   | Hospital:  |  | Othor  | ,.   | th (Check only one                           |  | 16   |
| o                   | Phys<br>this<br>ral dii   | <u>1</u>       | 1 Yes 2 No   | 1 ☐ Inpation   |  | IL 3 DOA   | 4 LI Nursing Ho                                      | ome 5 Reside                                 | nce 6 Other (Specif                                  | y) Tozace  |
| on                  | ding I<br>h.<br>After<br>funer  | lion           | 1 Natural 5 □ Pend   | (4.4. 41. 15.  |  | Work?  | es 2 □No   | 200. Describe no                             | w injury occurred                                    |  |
| Division or         | al or Attending Physician:<br>after death.<br>I Director: After this certifica<br>d in by the funeral director, I   | Certification: | 3 Suicide 6 Could  | not be 28e. Place of inj   | ury - At home, farm, str<br>c. (Specify) |  |  | 28f. Location (Str<br>City or Town           | reet and Number or Rura<br>, State)                  | al Route Number,   |
|                     | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral  | Medical C      | 29a. Certifier 1 Certify (Check only one) 1 Medica   | ring Physician: To the best<br>al Examiner: On the basis of<br>and manner st   | of examination and/or in                 | n occurred at the time<br>vestigation, in my op                    | e, date and place<br>inion, death occu               | , and due to the ca<br>rred at the time, da  | ause(s) and manner as s<br>ate and place, and due to | stated.<br>o the cause(s)                                |
| )                   | To the within 2 To the complet  | Σ              | 29b. Signature and title of codif  | An K   | Ly, as                                   | 29c, License   | number 5205  | 25   | Ad. Date signed (Month,                              | Day, Year)<br>25, 2008                                   |
|                     |   |                | WHIL   | n who completed cause of c   | 3mc                                      | 67011  | N. Ch  | ales   | St. for  | lto. ms  |
|                     | Sta<br>Registr  |                | 31. Date filed (Month, Day, Yea  | 7) 2008 Registr  | rar's Signature                          | K.   |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year John Thomas McDonald 2 11 2008 9:05A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital Leonardstown St. Mary's If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Director 215-07-6351 89 Dec. 21, MD 1918 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 ☐ Yes 2 XNo MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 USA 302 Newfield Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 If Yes, Give 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🗓 No Specify. \$ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Processor Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John T. McDonald Catherine L. Curtis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 Newfield Rd., Glen Burnie, MD 21061 Mrs. Johanna McDonald/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 19 1 N Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery 2008 4 Donation 5 DOther (Specify) Crownsville, MD 21. Signature I Pu eral/ ervice Licensee 22. Name and Address of Facility Singleton Funeral and Cremation M01411 1 2nd Ave. SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC Physician MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Be 25. Was case referred to medical examiner? \_ / 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient P 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending М 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

72 hours after

d 2 should be filed within the and Mental Hygiene.
7 Is marked other than "r

Department of Important: If it any Injury or c

use as the burial-tran

attending physician

s been signed by the should be detached

funeral director,

filled in by

death.

within 24 hours after death To the Funeral Director:

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, after

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier (Check only

one) 29b. Signature and title of certifie

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and add

29c. License number D0062937

29d. Date signed (Month, Day, Year)

31. Date filed /

of person who completed cause of death (Item 23a) (Type, Print) SVORODA MP

32 Registrar's Signature

25500 POINT LOOKOUT LOAD, LEONAND TOWN, MD 20650

State

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 12.30 AM Melvin F. Martin 2008 Toh /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE BALTIMORE N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 12 M 2 ☐ F 215-30-7117 73 Director Aug. 28, 1934 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits rai", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Gwynn Oak permit. Pages 1 and 2 should be filed within 72 hours after death with the I Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a any injury or other traumatic event, the Medical Examiner must be notifit 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1113 Baker Avenue 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **EN**0 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White ٥ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printer Business Forms 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 <u>Isabella</u> Melvin Ε. Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan E. Martin (Wife) 1113 Baker Ave., Gwynn Oak, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 2/15/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Tome 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DISEASE Physician COROMARY ARTERY /Medical Due to (or as a consequence of): FAILURE **Examiner** KESPIRATORY Cause thatly list conumors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tra Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a d be detached for 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown HUPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? cate ha 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No ၀ Certification:

Hospitai or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 within 24 hours after death

To the Funeral Director:
completely filled in by the

28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation Injury 1 Natural 1 □ Yes 2 □ No 2 Accident

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

(Check only 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Paisew H. WUNDETHINUT

10063327

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIZAW WOLDEHWOT, MD 2434 W. BELVEDERE AVE, BALTIMORE, MD 21215 32. Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year) 2008 FEB 14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                                |   |                | For State  | State of Maryland  |   | rtment of H   |                                |                                 | 71111   | 04286                             |  |
|--------------------------------|---|----------------|--|--|---|---|--------------------------------|---------------------------------|---|-----------------------------------|--|
| -                              |   | 7              | Registrar  1. Decedent's Name (First, Middle, Las  | t)   | 001   | incate or L   |                                | 2. Date of Death                | g. No.  | 3. Time of Death                  |  |
| e e                            | Physicia<br>/Medic  | _              | JAMES G.   | MCCLAIN  |   |   |                                | FEBRUAR                         |   |                                   |  |
|                                | Examin  | er             | 4a. Facility Name (If not institution, give<br>HARBOR HOSI   | street and number)   |   | 4b. City, Town, or BALTIM   |                                | ITY                             | 4c. County of Dea   | /A                                |  |
|                                | Funeral   |                | 5. Social Security Number 6. S   | ex 7. Age (In yrs. las   |   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | (Month, Day,                    | 9. Bir  | thplace (State or Foreign ountry) |  |
|                                | Director  |                | 218-01-8613 1 Usual Residence of Decedent  | B,M 2□F 87   | Yrs.  |   |                                | Oct. 31                         | 1920  | PA                                |  |
|                                | yland<br>now<br>at  |                | 10a. State 10b. County   | 10c. City, 1   | own or Lo   | cation  |                                |                                 |   | 10d. Inside City Limits           |  |
|                                | ne Mar<br>8a-fsl  | Director       | Maryland Anne A  | rundel   |   |   | n Burnie                       |                                 |   | 1 ☐ Yes 2 ☒ No                    |  |
|                                | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or Items 23a or 28a-f show<br>ith, the Medical Examiner must be notified at |                | 10e. Street and Number<br>6640 Whitmore Cou  | rt   |   | 10f. Zip Code   | 21061                          | 10                              | g. Citizen of What C<br>US  |                                   |  |
|                                |   | Funeral        | 11. Marital Status   | 12. Was Decedent Ever in U.S.<br>Armed Forces?                   | 13. \   | <br>Vas Decedent of Hi<br>f Yes, specify Cuba   |                                | pecify Yes or No-               | 14. Race - Am<br>Black, Whi   | erican Indian,                    |  |
| 36                             | rs after  | by Fu          | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced   | 1 ☑ Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates;                 |   | ☐ Yes 2 No  | Specify:                       |                                 |   | White                             |  |
| 0                              | 72 hou<br>natura<br>II. al E  | ted I          | 15. Decedent's Ed<br>(Specify only highest gra   | ucation  | 16a. Deced  | lent's Usual Occupa   | ation                          | king 1                          | 6b. Kind of Business  | s/Industry                        |  |
| 21                             | 2 should be<br>and Mental<br>Is marked c<br>aumatic eve   | Completed      | Elementary/Secondary (0-12)  | College (1-4or 5+)   | life. L   | OO NOT use retired  | )                              |                                 | la a <b>4</b> da a - 0  | Ada Ossaditis                     |  |
| 0<br>0                         |   | S              | 17. Father's Name (First, Middle, Last,  |  | SHEE  | t Metal V   |                                | ne (First, Middle, M            |   | <u>Air Condition</u>              |  |
| lan                            |   | To Be          | James G. McC   | lain Sr.   |   |   | Lily                           | Unkno                           | wn  |                                   |  |
| <b>Jary</b>                    |   |                | 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2  |  |   | ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Brickwall Lane, Pasadena, MD 21122 |                                |                                 |   |                                   |  |
| ė,                             | 1 and<br>Health<br>sm 27<br>ther t  |                | Darlene Coursey  20a. Method of Disposition  |  |   | sition (Name of natory or other place   |                                |                                 | Oc. Location - City o   |                                   |  |
| D III                          | Pages<br>nent of I<br>int: If Ite   |                | 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif  | removal from State   |   | <sub>natory or other plac</sub><br>Veterans   | 1 '                            | 1                               | rownsvill   | e, Maryland                       |  |
| Baltimore, Maryland 21215-0036 | permit. Pag<br>Department<br>Important: I<br>any Injury o   |                | 21. Signature of Funeral Service Licensee  22. Name and Address of Facility Stallings Funeral Home, P.A.  3111 Mountain Road, Pasadena, MD 21122   |  |   |   |                                |                                 | Home, P.A.  |                                   |  |
|                                | Physician<br>/Medical<br>Examiner   |                | 23a, art1. Enter the clease, or m  | plications that caused the death.                                |   |   |                                |                                 |   | Approximate                       |  |
|                                |   |                | 23a. Part 1. Enter the chease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail ure. List only one chiese in each line.  Immediate Cause (Final disease or condition)  a. ASTROINESTINAL BLEED  Approximate Interval Between Onset and Death 5 DA 75 |  |   |   |                                |                                 |   |                                   |  |
|                                |   |                | resulting in death)  | Due to (or as a conseque   |   |   |                                |                                 |   |                                   |  |
| 7                              | 70 ==   | ner            | Sequentially list conditions, if any, leading to immediate   | b  |   |   |                                |                                 |   |                                   |  |
| ٧                              | recuter<br>and<br>I-transi  | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last  | C  |   |   |                                |                                 |   |                                   |  |
| 8760,                          | cate be executed oblysician and the burial-transit  | dical E        |  |  |   |   |                                |                                 |   |                                   |  |
| 9                              | rtificate<br>ng phy<br>as the   | Medic          | JE EEN JE  | Su.  |   |   |                                |                                 |   |                                   |  |
| Вох                            | The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit  | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?   |  | 1 ☐Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy |   |                                |                                 | 23d. Date of delivery  Month Day Year   |                                   |  |
| P.O.                           |   | ysic           | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 4 □ Pregnant at time of death 5 □ Other (specify)<br>9 □ Unknown |   |   |                                |                                 |   |                                   |  |
| ords, P.                       | ss that<br>gned by  | by Pr          | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |                                |                                 | 23e. Did tobacco use contribute to the cause of death?                          |                                   |  |
|                                | w requires that<br>s been signed t<br>should be deta  | ted t          | ANEMIA, THROMBO CYTOPENIA, CONGULOPATH   |  |   |   | PATHY                          | 1 Yes 2 No 3 Probably 4 Unknown |   |                                   |  |
| Rec                            | ne law<br>has b   | Completed      | DIVERTI CULOSIS  |  |   |   |                                | autops                          | 24a. Was an autopsy findings available prior to completion of cause of death?   |                                   |  |
| Division or Vital Records,     | ospital or Attending Physician: hours after death. uneral Director: After this certifics ly filled in by the funeral director. I                                    | Be Co          | 1   Yes 2   No   1   Yes 2   No   No   No   No   No   No   No  |  |   |   |                                |                                 | es 2 No   |                                   |  |
|                                |   | To B           | examiner? 1 Yes 2 No   |  | ₹/Outpatier   | nt 3 DOA Oth  | 04                             |                                 | nce 6 □Other (Sp  | pecify)                           |  |
|                                |   | ion:           | 27. Manner of Death  1 Natural 5 Pending   | (Month, Day Year)  | 8b. Time o<br>Injury                                | Wor   |                                | 28d. Describe ho                | w injury occurred   |                                   |  |
|                                |   | ficat          | 2 Accident investigatio 3 Suicide 6 Could not b  |  |   |   |                                |                                 | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |                                   |  |
|                                |   | Certification: | 4 ☐ Homicide determined  |  |   |   |                                | City or Town                    |   |                                   |  |
|                                |   | Medical        | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Description of the death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |                                |                                 |   |                                   |  |
|                                | To the H<br>within 24<br>To the Fi<br>complete  | Me             |  |  |   |   |                                |                                 |   | Date signed (Month, Day, Year)    |  |
| )                              | ,   |                | 15/2   | M·D  | W-1 (T  |   | 5000                           |                                 | EBRUARY   | 11112008                          |  |
|                                | 5   |                | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  BHUPESH PANWAR, 3001 SOUTH HANOVER STREET, BALTIMORE, M.D. 21225   |  |   |   |                                |                                 |   |                                   |  |
| s,                             | State 31. Date filed (Month, Day, Year) 4. Registrar's Signature  |                |  |  |   |   |                                |                                 |   |                                   |  |
|                                | Regist  | rar            | red 14 Zu  | OU SEE WEST SO   | 1   |   |                                |                                 |   |                                   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DYSPM Physician Month MIXON ara 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 0denton <u>490 N Patuxe</u>nt Road If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) March 21 6. Sex 9. Birthplace (State or Foreign Funera! 1 M 2 TF 82 Months Days Hours Min. Mary I and 219-10-1653 1925 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 386 Alameda Pkwy. 21012 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (X)No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teller Banking permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if item 27 is marked oth any Injury or other trailments. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Cook Nola Lowry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) son 490 N Patuxent Road Odenton MD 21113 Thomas Mixon 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb 15 2008 Pasadena Maryland Mt Carmel 21. Sign turn of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home P.A. <u>3111 Mountain Rd Pasadena MD 21122</u> 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on fach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** year /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trans and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: for use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 : autops perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Hother (Specify) 5 N's hand ဥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 8005 of person who completed cause of death (Item 23a) (Type, Print) 10 R2 Sute 300 Annapolis MD 900 Bestante 31. Date filed (Month, Day, Year) 32. Registrar's Signature. State

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008 Flburary <u>Katharine W. Nickey</u> 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Square Kosedale If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1/26/1917 Hours 1 □ M 2 🔀 F Days West Virginia 91 218-01-7281 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2x3xNo MD Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8800 Walther Blvd #204 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. 1 Tes 2011 If Yes, Give Year or Dates: 1 Never Married 2 Married 2XXV0 1 ☐ Yes ¾XNo Specify: Specify: White 3xXWidowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Mav Cornelius Walter Bruce Wills 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 55 Park Road Wyomissing Hills, PA 19609 John Nickey / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2/16/2008 Dulaney Valley Mem. Timonium, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Towson, Maryland 21204 1050 York Road Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death pirato Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknowr 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 X No 3 Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Natural 2 Accident 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be

**Physician** /Medical Examiner certificate be executed and Box 68760, attending physician for use as the buria the SS esn signed by the a P.0. Division or Vital Records,

Examiner Physician/Medical certificate has this After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After the

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

"natural", or Items 23a or 28a-f shovidical Examiner must be notified at

7 is marked other than "nature traumatic event, the Medical

and Mental

permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once.

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

Be

P

þ Completed Be ၉ Certification: completely filled in by Medical

31. Date filed (Month, Day, State Registrar

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

empleted cause of death (Item 23a) (Type, Print)

and manner stated.

1 > ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

9000 Franklin

Year

Location (Street and Number or Rural Route Number, City or Town, State)

32 Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jeannette Osborne February 2008 12:35P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 730 Southern Hills Drive Arnold Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 84 Yrs. 143-14-8329 Director March 4,1923 Canada Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified at MD Anne Arundel 1 ☐ Yes 2 ☑ No Director Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 730 Southern Hill Drive 21012 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ᡚ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+ Material Analyst 12 Computers 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Demers Alice Beauriuage ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwyn Tober (Daughter) 624 Breton Place Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 2/11/08 Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd. Elkridge, MD 21075 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or not art failure. List only one cause on each line. wans Approximate Interval Between Onset and Death Immediate C se (Final disease or condition resulting in death) **Physician** ANCREATIC ANCEN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and burial-transit Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: for use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes ♣️ No 24a. Was an certificate has page 2: 1 Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? e Hospital or Attending Pl 24 hours after death. e Funeral Director: After ti 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 | Homicide e Funeral 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the I within 2 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) み4768 218108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARNOUD 1N8UM Year) 32. Pagistrar's Signatur 31. Date filed (Month, Day,

State

Registrar

FEB

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records,

- Bus

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 40 AM February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN Square
5. Social Security Number 6. Se Rosedale
If Under 1 Year | If Under 24 Hrs. Center Baltimore HUSPITAL 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Hours 1 □ M 2 □ 218-42-0278 Usual Residence of Decedent Director 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Baltmore Funeral Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ral", or items 23a or : Examiner must be n Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ 16 If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or Completed by 3 Nidowed 4 □ Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NQT use retired) Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be in Department of Health and Mental Important: If Item 27 is marked or ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GINA Kinsh 20b. Place of Disposition (Name of cemetery, crematory or other place) DUNGS 2/222 20a. Method of Disposition 20c. Location - City or Town, State important: If It any injury or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CRd. 21222 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PD 0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Unicated or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-tran Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performe 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Box 68760, P.0. Division or Vital Records,

filed within 72 hours after death with the Maryland Hygiene.

Barbara

21215-0036

Baltimore, Maryland

MS

that the death certificate be executed has this certificate To the Hospital or Attending Physician: After death. within 24 hours after death To the Funeral Director: , completely filled in by the f

State Registrar 29a. Certifier (Check only one)

29b. Signature and

31. Date filed (Month, Day, Year)

EB

30. Name and address who completed cause of death (Item 23a) (Type, Print) Jam Welker

4

of certifie

9000 FRANKLIN

and manner stated

32. Registrar's Signature 1865

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

H0052024

29d. Date signed (Month, Day, Year) 80

21237

Amend 4c, State of Maryland, Department of Health and Mental Hygiene State
Registrar Amend #4a, perMD, g876, 2/14/08 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2 08 12:05 a<sup>M</sup> Elsie Pennewell /Medical 4a. Facility Name (If not institution, give street and number)
Arc of Northern Chesapeake 4b. City, Town, or Location of Death 4c. County of Death Harford Examiner Belair Joppa If Under 1 Year Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1□M 2□ Hours Min. Months Yrs MD 218-66-1419 Director 1-2-1925 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10b. County Harford 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Directo MD Joppa **Belair** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21085 1515 Philadelphia Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 9 Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A7th\_grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fil f Health and Mental H tem 27 is marked oth Be Thomas Pennewell ٩ Dorothy Brittingham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) At. Pages 1 and 2. It have not of Health ar. Darlene Pennewell-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Penn Grove, N.J. 08069 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) permit. Pages Department of Important: If it any injury or o 3 ☐Removal from State MtCarmel Cemetery 2-15-2008 MD 21. Signature of Fundal Service Licenses 22. Name and Address of Facility March F/H East Balto, 21202 North Avenue 1101 E. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transi and Due to (or as a consequence of): attending physician at for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 ☐ Other (specify) detached sbeen signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 1 ☐ Yes 2 ☐ No perform 1☐ Yes or Attending Physician: 25. Was case referred to medical examiner? director Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and litt of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Spect 2014 Tollgate Rd 31. Date filed (Month, Day, Year) 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

FEB 14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 3:55A FEB.13,2008 /Medical VALERIE PARKER 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE N/A JOSEPH RICHEY HOSPICE 8. Date of Birth (Month, Day, Year) FEB.14,1963 MD. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 □ Months Min. Yrs. 161 54 0221 44 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Exaπlner must be notified at 1 Yes 2 □ No Director BALTIMORE N/A MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with 21218 USA 123 W. 29th St. APT. 11D Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes & E No Specify Specify: BLACK ò 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
CNA (certified nursing 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) LORIEN NURSING Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12TH aggt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROSALIND O'NEIL CLAUDE E. PARKER SR. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) KIERA BARKSDALE (daughter) 1205 N.LINWOOD AVE. BALTO, MD. 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If its any injury or o Burial 2 Cremation 3 Removal from State MT.ZION CEM. FEB. 20,2008 BALTO, MD. anature of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME 21213 1412 E PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that caused the plant. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on lach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Examiner Sequentially flet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transit **₩**₽ Due to (or as a consequence of) 68760 attending physician certificate be Physician/Medical Box IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month detached for Day 5 Other (specify) 1 ☐ Yes 2 ☑ No P.O. the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 □ Yes 2 No 3 Probably 4 □Unknown Completed Ab. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has performed? Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ٩ 1 Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manual of Death 28a Date of Injury 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Vital Records, Division or

3

State

29b. Signature and title of certifie

DHMH 17 Rev 1/2001

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William G. Rothame1 February 09 2008 3:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Future Care Severna Park Anne Arundel 5. Social Security Number 8. Date of Birth (Month, Day, July 22 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Year) 1 M 2 □ F 220-24-5868 91 Director 1916 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at Director Maryland Anne Arundel 1 ☐ Yes 2 No Pasadena 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? ral", or items 23a Examiner must b 532 Grays Creek Road 21122 USA death Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 'natural", or Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☐ Divorced Specify: permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Builder Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Rothame1 Mary Yanyon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Rothamel (brother) 450-A Man-O-War Court, Annapolis, MD 21409 Date 13 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Feb. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery Glen Burnie, Maryland 2008 21. Signature Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD\_21122 23a. Part1. Enter the disease, or comply atio shock, or heart failure. List only one ca s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ceedial /Medical Due to sa consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical the 33 IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death i signed by the a 5 Other (specify) P.0. 1 Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably Dunknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page this certificate 2 No 1□ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place eath Check only one) 2 Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28h Time of 28d. Describe how injury occurred Certification: After Natural 5 ☐ Pending investigation To the Hospital or Attention, within 24 hours after death.

To the Funeral Director: Aft 1 Yes 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature title of certifier 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State FEB 1 4 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04295 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month SINGER M. 12:30 PM JACQUELYN 08 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore County Baltimore 9107 Lincolnshire Court Apt. E If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 F Yrs. 215 30 2784 75 February 9 1933 Baltimore, Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2√√No Baltimore County Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 USA 9107 Lincolnshire Court Apt. E Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □ Yes 2 🗙 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 XXNo Specify. Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) N/A Elementary/Secondary (0-12) Bill Kidds Timonium Toyota Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Marie Folker James Russell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9400 Gunview Road Baltimore, Maryland 21236 Debora M. Henkelman 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐ Removal from State Parkwood Cemetery February 15 2008 Baltimore, Maryland 22. Name and Address of Facility Lassahn Funeral Home Inc 21. Signature of Funeral Service Dicensee 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to a consequence of): disease or condition resulting in death) hronic alcohol Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last tobacco hronic Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

certificate be executed

or Attending Physician:

Division of Vital Records, P.O. Box 68760

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

**Funeral** 

Director

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

d 2 should be filed within 7; th and Mental Hygiene. 7 is marked other than "n.

of Health item 27 i

permit. Pages 1
Department of Hi
Important: If iter
any injury or oth

Baltimore, Maryland 21215-0036

physician and s the burial-trans Physician/Medical attending p ate has been signed page 2 should be det þ Completed Be Certification: To after death. the

24a. Was an autopsy performed' 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No 27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

5 ☐ Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day

28b. Time of

28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier

29c. License number D47563 29d. Date signed (Month, Day, Year) 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9524 BELAIR RD BALTIMORE MD PATRICIA CHAMBLISS, MD

State Registrar

filled in by

Medical

To the Hospital o within 24 hours aff To the Funeral D completely filled in

31. Date filed (Month, Day, Year) 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Cornelia E. Sykes 330AM February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 214-18-1522 1 □ M 2 🗙 F 85 Director <u> April 17,1922 Virginia</u> Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show "natural", or items 23a or 28a-f shov edical Examiner must be notified at N/A MD Baltimore XXYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 725 N. Grantley Avenue 21229 by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2XXXIIIO If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 N Widowed 4 □ Divorced Year or Dates: Completed injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) than, 12th Grade College (1-4or 5+) Clerk Hospital permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important: If Item 27 is marked other trainmatic any Injury or other trainmatic contents. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arizona Johns Unknown ပ္ 19a. Informant's Name/Relationship (Type. Print)
Kathleen Weaver/ Cousin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5534 Bucknell Rd. Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Mt. Carmel Cemetery 2/15/08 Dundalk, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 4210 Belair Rd. Baltimore, MD 21206 arris 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician one day monar disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Kena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit be executed Diubetes Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Tes 2 No 3 Probabiy 4 Unknown Corunary Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA After this funeral 28c. Injury at Work? To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; After it completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

East University 2. Registrar's Signature

Stephen NGUX.
31. Date filed (Month, Day, Year)
70 1 4 2008

FEB

00063163

Parkway Delhiner Manylan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] ? 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yeer **Physician** loann 2008 6:10 February 11 /Medical 4a. Facility Name (It not institution, give sheet and number)
Pleasant View Norsing Ha 4b, City, Town, or Location of Death 4c. County of Death Examiner Home If Under 1 Year It Under 24 Hrs.

Months Days Hours Min. Maryland Carroll 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 20XF 66 2983 Director 42 NOV 20 194 Usual Residence of Decedent death with the Maryland 10a, State 10c. City, Town or Location worle 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Manical Examination ust be molfied at CARROLL 1 Yes 2 □ No Director MO 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4101 NATIONAL Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced te Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) VISABLED 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hisant: If item 27 is marked other. SUNDAY SHIPLEY FRAIley HOMER Jean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYNN Shipley 21117 1A REGALIA COURT OWINGS MILLS MY SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. injury or 2-16-2000 TANGYTOWN, MY 4 ☐ Donation 5 ☐ Other (Specify) GRACE UNITED CEM 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JN Zumn un 151 & mon Co 23a. Part Enter the diseased or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. FUSERSBURG 21784 Approximate Interval Between Onset and Death Immediate Cause (Final Physician MIN WHED disease or condition resulting in death) /Medical Due to for as a conseque Examiner Social title is a concitions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the attending physician and hed for use as the burial-transit be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 20 No 1 Yes 22 No 1 TYAS 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and Me of certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 231 Type, Print) 9501 lan 31. Date filed (Month, Day, Year) 32. Recistrar's Signature 21045 State

DHMH 17 Rev 1/2001

Registrar

|             |   |                  | For State   | State                             | of Maryla                                   |                                      | artment of I  |                              |                           | •                                  | - 1                      | 2008                             | 04298   |
|-------------|---|------------------|---|-----------------------------------|---|--------------------------------------|---|------------------------------|---------------------------|------------------------------------|--------------------------|----------------------------------|---|
|             | -   |                  | Registrar  1. Decedent's Name (First, Middle,   | Loot                              |   | Cei                                  | rtificate of  | Deam                         |                           | 2. Date of De                      | Reg. No. (               | 2000                             | 01.22   |
|             | Physicia  | an               |   | ,                                 |   |                                      |   |                              |                           | Month                              | Day                      | Year                             | 3. Time of Death                              |
|             | /Medic  |                  | Patricia Shelton  |                                   |   |                                      | 41 001 7  |                              |                           | Februar                            |                          |                                  | 23:20p <sup>M</sup>                           |
|             | Examin  | er               | 4a. Facility Name (If not institution,  |                                   |   |                                      | 4b. City, Town, o   |                              | of Death                  |                                    |                          | County of Death                  |   |
|             |   |                  | Southern Marylan  5. Social Security Number   | id Hospit<br>6. Sex               |   | rs. last birthday)                   | Clinton<br>If Under 1 Year                                  |                              | 24 Hrs T                  | 8. Date of Bir                     |                          | nce Geo                          | orge's<br>place (State or Foreign             |
|             | Funeral Director  |                  | 579-40-7037   | 1 □ M 2 <b>X</b> F                | 7. Age (III y                               | Yrs.                                 | Months Days   | Hours                        | Min.                      | (Month, Da                         | y, Year)                 | Cou                              | ntry)   |
| 1-          |   |                  | Usual Residence of Decedent   |                                   |   | +                                    |   |                              |                           | 12-12-                             | 1930                     | NOIL                             | h Carolina                                    |
|             | yland<br>yland<br>at  |                  | 10a. State 10b. County  |                                   | 10c.  | City, Town or Lo                     | cation  |                              |                           |                                    |                          |                                  | 10d. Inside City Limits                       |
|             | Mar<br>fled   | ţ                | MD Prince   | George's                          | Di  | strict 1                             | Heights   |                              |                           |                                    |                          |                                  | 1 X Yes 2 ☐ No                                |
|             | r the   | irec             | 10e. Street and Number  | occine s                          |   |                                      | 10f. Zip Code   |                              |                           |                                    | 10g. Citiz               | en of What Cou                   | ntry?   |
|             | 23a c   | alD              | 2302 Bentonia Co  | urt                               |   |                                      | 20747   |                              |                           |                                    | USA                      |                                  |   |
|             | be filed within 72 hours after death with the Maryland<br>that Hygiene.<br>ed other than "natural", or Items 23a or 28a-f show<br>event, the Medical Examiner must be notified at | Funeral Director | 11. Marital Status  | 12. Was Dec<br>Armed F            | edent Ever in                               | U.S. 13.                             | Was Decedent of I   | Hispanic Ori                 | igin? (Spe                | cify Yes or No                     | - 1                      | 4. Race - Ameri<br>Black, White, |   |
| õ           | or it   |                  | 1 Never Married 2 Mamie   | ed 1 Tyes<br>If Yes, G            | ive No                                      |                                      | 1 ☐ Yes 2 ☒ No  |                              |                           |                                    | ì                        | Specify: Bla                     |   |
| 9500-51212  | ural",  | d by             | 3 ☐ Widowed 4 🛱 Divorced  | Year or I                         | Dates:                                      |                                      |   |                              |                           |                                    |                          |                                  |   |
| Ÿ           | "nati   | Completed        | 15. Decedent'<br>(Specify only highes   | s Education<br>grade completed,   | )   | 16a. Dece                            | dent's Usual Occu<br>kind of work done<br>DO NOT use retire | pation<br>during most        | t of workir               | ng                                 | 16b. Kin                 | d of Business/Ir                 | ndustry                                       |
| 7           | withir  | m                | Elementary/Secondary (0-12)   | College                           | (1-4or 5+)                                  |                                      |   | <i>(a)</i>                   |                           |                                    | D                        | W                                |   |
|             | Hygie<br>Hygie<br>Ther<br>nt, th  | ပိ               | 9th<br>17. Father's Name ( <i>First, Middle, L</i>  | asti                              |   | Domes                                | t1c   | 18 Mothe                     | ar'e Namo                 | (First, Middle                     |                          | vate                             |   |
| /land       | 0 m 0 %   | Be o             | Roland C. Pullia  | ,                                 |   |                                      |   |                              |                           | . Will:                            |                          | ourname)                         |   |
|             | 2 should be<br>and Menta<br>is marked<br>raumatic ev  | 우                | 19a. Informant's Name/Relationsh  |                                   |   | 19h Mailir                           | ng Address (Street  |                              |                           |                                    |                          | Town State 7                     | n Coda)                                       |
| Mar         | id 2 s<br>Ith arr<br>27 is<br>trau  |                  | Ella C. Shelton/  |                                   |   |                                      | Bentonia  |                              |                           |                                    |                          |                                  |   |
| ē,          | es 1 and 2<br>of Health a<br>fitem 27 Is<br>r other trai  |                  | 20a. Method of Disposition  |                                   |   | . Place of Dispo                     | sition (Name of<br>matory or other pla                      | . !                          | D                         | ate                                | 20c. Loc                 | ation - City or T                | own, State                                    |
| saltimore,  | Pages<br>nent of I<br>ant: If ite   |                  | 1 ☑ Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (Sc  |                                   | Jolale                                      |                                      | matory or other pla<br>tion Ceme                            | 4                            | 2-16                      | -2008                              | CIT                      | NTOW, A                          | AN.   |
|             | artme<br>ortan<br>injur   |                  | 21. Signature of Funeral Service L  | 1                                 |   |                                      |   | -                            |                           |                                    |                          | •                                | me of MD.                                     |
| ñ           | permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 is marked any injury or other traumatic er  |                  | Donald Gray   | MIK                               | 14  |                                      | 308 Suit:   |                              |                           |                                    |                          |                                  |   |
| П           |   |                  | 23a. Part1. Enter the disease, or shock, or heart failure. List of  | complications that                | caused be de                                |                                      |   |                              |                           |                                    |                          |                                  | Approximate                                   |
|             | Physician   |                  | Immediate Cause (Final  | only one cause on                 | eachture                                    |                                      | 11.5  | 1 m                          | DIIL                      |                                    | - 11-                    | _                                | Interval Between<br>Onset and Death           |
| j -         | /Medical  |                  | disease or condition resulting in death)  | a. Due to                         | (or aspa cons                               | vector of).                          | <u>xau</u>  | 1-1                          | en                        | 02                                 |                          |                                  | Talay   |
|             | Examiner  |                  |   | W 540 to                          | 100   | 1 DA                                 | tia   |                              |                           |                                    |                          |                                  | 500   |
| ŭ           |   | Jer              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b                                 | (or as a cons                               | equence of):                         | 2   |                              | 1                         | /                                  |                          |                                  |   |
|             | uted<br>d<br>ansit  | Examiner         | Cause. Enter Underlying Cause (Disease or injury that initiated events  |                                   | rlee  | 1806                                 | LA  | m                            | Lal.                      | ance                               | -                        |                                  | 70  |
| Ď,          | exectan an an rial-tr   | Exa              | resulting in death) Last  | Due to                            | (or as a cons                               | equence of):                         |   |                              |                           |                                    |                          |                                  |   |
| 8/6U        | icate be executed<br>physician and<br>s the burial-transit  | dical            | 1   | d                                 |   |                                      |   |                              |                           |                                    |                          |                                  |   |
| 9           | rtifica<br>ng ph<br>as th   | യ                |   |                                   |   |                                      |   |                              |                           |                                    |                          |                                  |   |
| X<br>Q<br>Q | death certifi<br>e attending<br>d for use as  | sician/M         | IF FEMALE:<br>23b. Was decedent pregnant  |                                   | utcome pf preg                              |                                      | ]Ectopic pregnanc   | 21/                          |                           |                                    | 2                        | 3d. Date of deliv                | ,   |
|             | e dea   | sici             | in the past 13 months?<br>1 ☐ Yes 2 ☐ No  |                                   | nant at time o                              |                                      | Other (specify)   |                              |                           |                                    |                          | Month                            | Day Year                                      |
| л<br>Э      | at the  | Phys             | 9 ☐ Unknown   |                                   |   |                                      |   |                              |                           |                                    |                          |                                  |   |
|             | w requires that the death certifi<br>been signed by the attending I<br>should be detached for use as  | by F             | Part II. Other significant conditio   | ns contributing to                | death but not r                             | esulting in the u                    | nderlying cause gi  | ven in Part I.               |                           |                                    |                          |                                  | the cause of death?                           |
| Records,    | equir<br>sen s  | ted              |   |                                   |   |                                      |   |                              |                           | 1 🗆                                | Yes 21                   | No 3 ☐ Pro                       | bably 4 Unknown                               |
| ပ္တ         | law r<br>as be<br>2 sh  | Completed        |   |                                   |   |                                      |   |                              |                           | 24a. Was                           |                          | 24b. Were aut                    | opsy findings available ompletion of cause of |
|             | slcian: The law certificate has b irector, page 2 s   | Com              |   |                                   |   |                                      |   |                              |                           | perfo                              | rmed?                    | death?<br>1 ☐ Yes                |   |
| Vital       | yslcian:<br>is certific<br>director,  | Be (             | 25. Was case referred to medical examiner?  |                                   | ,   |                                      |   | 26. Place                    | of Death                  | (Check only                        | one)                     |                                  |   |
| 0           | Q 5.  | Tol              | 1 ☐ Yes 2 ☐ No  | Hospital: 1                       | Inpatient 2                                 | ☐ ER/Outpatier                       | nt 3□ DOA Ot  | her:<br>4 □ Nu               | ursing Hor                | me 5 □ Resi                        | dence 6                  | □Other (Spec                     | ify)  |
|             | ng P  |                  | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending   | 28a. Date<br>(Mo.                 | e of Injury<br>nth, Day Year,               | 28b. Time o<br>injury                | f 28c. Inju   | ry at<br>rk?                 | 2                         | 28d. Describe                      | how injury               | occurred                         |   |
| <u> </u>    | endl<br>eath.<br>or: A  | atio             | 2 ☐ Accident investig   | ation                             |   |                                      | M 1   | Yes 2                        | No                        |                                    |                          |                                  |   |
| UIVISION    | ter de lirect   | Certification:   | 3 ☐ Suicide 6 ☐ Could n<br>4 ☐ Homicide determi   | ned   28e. Plac                   | e of injury - Al<br>ding, etc. <i>(Sp</i> e | t home, farm, sti<br>ec <i>ify)</i>  | eet, factory, office  |                              | 2                         | 28f. Location (<br>City or To      | Street and<br>wn, State) | Number or Rui                    | ral Route Number,                             |
|             | spital or Attending Phours after death. reral Director: After th  |                  |   |                                   |   |                                      |   |                              |                           |                                    |                          |                                  |   |
|             | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer   | edical           | 29a. Certifier 1 Certifying (Check only one) 2 Medical 8  | Physician: To the xaminer: On the | basis of exam                               | (nowledge, deat<br>ination and/or ir | h occurred at the to<br>vestigation, in my                  | ime, date an<br>opinion, dea | nd place, a<br>ath occurr | and due to the<br>red at the time, | cause(s)<br>date and     | and manner as place, and due     | stated.<br>to the cause(s)                    |
|             | To the Hos<br>within 24 h<br>To the Fun<br>completely   | Med              | 29b. Signature and title of certifier   | and ma                            | nner stated.                                |                                      | 29c kicen   | se number                    |                           |                                    | 20d Date                 | signed (Month                    | Day Voorl                                     |
|             | N I W   |                  |   | -2 ^                              | 1   |                                      | 500   | -7-11                        | 531                       | 5                                  |                          | signed (Month                    |   |
| ,           | 7   |                  | V   | V                                 | V 2   | 25.15                                |   |                              |                           |                                    | VZ                       | , 11.02                          | 2   |
| 2           | 1   |                  | 30. Name and address of person v<br>Laxmi Berwa, MD   | vno completed cau<br>7700 OI      | use of death (1:<br>_d Bran                 | iem 23a) (Type,<br>.ch Aven          | ue #101,  | Clint                        | ton,                      | Maryla                             | nd 20                    | 735                              |   |
|             | Sta   | to               | 31. Date filed (Month, Day, Year)   |                                   | Registrar's Sig                             |                                      |   |                              |                           |                                    |                          |                                  |   |
|             | Registr   |                  |   | ana A.                            |   | e. e                                 |   |                              |                           |                                    |                          |                                  |   |

ORIGINAL

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 02<sup>Month</sup> **Physician** 10 Elizabeth L. Schaible /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🕱 F 213-10-7937 96 Director 12/07/1911 Usual Residence of Decedent 10c. City, Town or Location 10b. County 28a-f show Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified. MD Baltimore Phoenix 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13617 Bardon Road 21131 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 7:34 p.m, ☐Yes 2**X** No Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2K No þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Longbottom Olive McClain 10, 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvin Schaible/Son 13617 Bardon Road, Phoenix, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State FEBRUARY 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Memorial02-14-08 Timonium, MD 4 □ Donation 5 □ Other (Specify) Gardens 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 21. Signature of Fyneral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atheroscleratic Cardiovascular Disease Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence burial-transit Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria or Vital Records, P.O. Box 68760 Physician/Medical ELIZABETH SCHAIBLE IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an autopsy page 2 s has performed? Yes 2**X** No certificate To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) or Attending 5 ☐ Pending investigation 1 X Natural 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 3108 TIMONIUM, MD 21093

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Month

3. Time of Death

7:34

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 X No

2008

USA

Specify:

21131

Own Home

Baltimore

MD

14. Race - American Indian,

White

Black, White, etc.

рм

DHMH 17 Rev 1/2001

Registrar

DR.

TARIQ MAHMOOD

4 2008

31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD.

22. Registrar's Signature

|             |  |                | 1 - For<br>State<br>Registrar   | State of Ma   | arylan                    |                         | artment<br>rtificate                       |                                |                   | Mental Hy                            | giene<br>Reg. No.         | / 11111                   | 3             | 04300  |   |
|-------------|--|----------------|---|---|---------------------------|-------------------------|--|--------------------------------|-------------------|--------------------------------------|---------------------------|---------------------------|---------------|--|---|
| В           |  |                | 1. Decedent's Name (First, Middle,  | Last)   |                           |                         |  |                                |                   | 2. Date of D<br>Month                | eath                      |                           |               | 3. Time of Death                             | - |
|             | Physici<br>/Medic  |                | PATRICIA 1.   | IENRIETT.   | 4                         | SMY                     | SLE  | Υ                              |                   | 02                                   | 0 <b>7</b>                |                           |               | 2 A M  |   |
|             | Examin   | er             | 4a. Facility Name (If not institution,  |   |                           | -4 1                    |  | ,                              | ocation of Dea    | th                                   |                           | County of De              |               | - 00-10                                      |   |
| - 2         |  |                | LAUREL REG  5. Social Security Number 6   |   |                           | A L. last birthday)     | LA<br>If Under 1                           |                                | If Under 24 Hrs   | 8. Date of B                         |                           |                           |               | ORGES  | _ |
|             | Funeral<br>Director  |                | 223-32-4401   | 1□ M 2⊠ F   | 79                        | Yrs.                    | Months                                     | Days                           | Hours Min         |                                      | av. Year)                 | 1 (                       | Country)  Mex |  |   |
|             | ъ  |                | Usual Residence of Decedent   |   |                           |                         |  |                                |                   |                                      |                           |                           |               |  | _ |
|             | arylar<br>show   | ř              | 10a. State 10b. County  |   | 10c. City                 | , Town or Lo            | cation                                     |                                |                   |                                      |                           |                           |               | Inside City Limits  1 Yes 2 No               |   |
|             | the M<br>28a-f<br>otifie   | Director       | Maryland Prince ( 10e. Street and Number  | eorges  | Lau                       | rel                     | 10f. Zip C                                 | `ada                           |                   |                                      | 10a Citi                  | zen of What (             |               |  | _ |
|             | with 3a or   |                | 15817 Wayne Ave   |   |                           |                         |  |                                |                   |                                      |                           | zen or winat t            | Journey :     |  |   |
|             | death<br>ms 2;   | Funeral        | 11. Marital Status  | 12. Was Decedent E  | Ever in U.                | S. 13. \                | Vas Decede                                 |                                | panic Origin? (   | Specify Yes or N<br>rto Rican, etc.) | o- USA                    | 14. Race - An             |               |  | _ |
| 9           | filed within 72 hours after death with the Maryland<br>Hygiene.<br>other than "natural", or items 23a or 28a-f show<br>ent, the Medical Examiner must be notifled at   |                | 1 Never Married 2 Married   | 12. Was Decedent E<br>Armed Forces?<br>1 ☐ Yes 2 <b>X</b> N<br>If Yes, Give | 10                        |                         | itYes, specit<br>1∐Yes 2[                  | v                              | Specify:          | rto Rican, etc.)                     |                           | Black, Wh                 |               |  |   |
| 21215-0036  | hours<br>ural",  | d by           | 3 ☑ Widowed 4 ☐ Divorced  | Year or Dates:  |                           | 1                       |  |                                |                   |                                      | 150                       | Specify:                  | Whit          |  | _ |
| 7           | in 72<br>"nat  | Completed      | 15. Decedent's (Specify only highest  | grade completed)  |                           | (Give                   | dent's Usual<br>kind of work<br>DO NOT use | occupat<br>done du<br>retired) | ring most of wo   | orking                               | 16b. Ki                   | nd of Busines             | ss/Indust     | try  |   |
| 212         | d with<br>giene<br>r thai  | mo             | Elementary/Secondary (0-12)   | College (1-4or 5-   | +)                        | Foreign                 |  |                                |                   |                                      | Sta                       | te Depar                  | tmen          | t  |   |
| b           | al Hyl<br>f othe<br>vent,  | Be C           | 17. Father's Name (First, Middle, La  | st)   |                           | _                       |  |                                | 18. Mother's Na   | me (First, Middle                    | e, Maiden                 | Surname)                  |               |  |   |
| yla         | ould to  | 2              | Alfonso H. Sanche   |   |                           | 1                       |  |                                |                   | a Candelar                           |                           |                           |               |  |   |
| Maryland    | d 2 sh<br>th and<br>7 is m<br>traum  |                | 19a. Informant's Name/Relationship<br>Carol Nottingham- si                                      |   |                           | 1                       |  |                                |                   | lural Route Numi<br>fax, VA 22       |                           | r Town, State             | , Zip Co      | de)  |   |
| ē,          | tem 2  |                | 20a. Method of Disposition  |   | 20b. P                    | lace of Dispo           | sition (Name                               | of                             | 1                 | Date                                 | ,                         | cation - City of          | or Town,      | State  | _ |
| Baltimore,  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. |                | 1 ☐ Burial 2 【☐ Cremation 3<br>4 ☐ Donation 5 ☐ Other (Spe                                      |   | Metr                      | emetery crer<br>opolita | n Crema                                    | tory                           | 2/8/              | 2008                                 | Alex                      | andria,                   | Virg          | inia   |   |
| aĦ          | mit. partm portal  |                | 21. Signature of Funeral Service Lie  |   |                           | 22                      | Name and                                   | Address                        | of Facility Home, | INC                                  |                           |                           |               |  | 7 |
| <u> </u>    | 8 3 1 6 8  |                | Magan   | MO1234  |                           |                         | 7601 Sa                                    | ndy S                          | pring Rd          | , Laurel,                            | Mary1                     | and 2070                  | 7             |  |   |
| P           |  |                | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List or                        | mplications that caused<br>ly one cause on each lin                         | the death                 | n. Do not ent           | er the mode                                | of dying                       | , such as cardia  | c or respiratory                     | arrest,                   |                           | Ap<br>Int     | proximate<br>erval Between<br>nset and Death |   |
|             | Physician /<br>/Medical  |                | Immediate Cause (Final disease or condition resulting in death)                                 | a. ACUTE<br>Due to (or as a   | - C                       | ORONA                   | 1Ry  | Sy                             | NDROA             | IE                                   |                           |                           |               | Tool and Death                               |   |
|             | Examiner   |                |   | Due to (or as a   | a consequ                 | uence of):              | 10-6                                       | = 1 \                          | 1010              | -11-                                 |                           |                           |               |  |   |
|             |  | ner            | Se uentially list conditions if any, leading to immediate                                       | b. CoRon  | a consequ                 | uence of):              | KIL  | 1                              | 013               | CHZC                                 |                           | -                         |               |  | - |
|             | nd A transit   | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | · PROF  | DUN                       | D A                     | NER  | 111                            |                   |                                      |                           |                           |               |  |   |
| 90          | oe exe   | EX             | resulting in death) Last  | c. PROF<br>Due to (or as a  | a consequ                 | uence of):              |  | _                              | 2 ( 4             |                                      |                           |                           |               |  |   |
| 68760,      | eath certificate be executed attending physician and for use as the burial-transit   | edical         |   | d. CHEI   | 40T                       | HERA                    | 7 r y                                      | FOR                            | Z CA              | NCER                                 |                           |                           | +             |  | _ |
| Box (       |  | n/Me           | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome p  |                           |                         |  |                                |                   |                                      |                           | 23d. Date of d            | lelivery      |  |   |
|             | death<br>e atte  | Physician/M    | in the past 12 months?<br>1 ☐ Yes 2 ☑ No  | 1 ☐Live birth 4 ☐ Pregnant at   |                           |                         | ]Ectopic preg<br>]Other (sp <i>e</i>       |                                |                   |                                      |                           | Month                     | Day           | y Year                                       |   |
| <u>о</u>    | at the<br>by th  | hys            | 9 Unknown   | 9L]Unknown  |                           |                         |  |                                |                   |                                      |                           |                           |               |  |   |
|             | The law requires that the death certi<br>ate has been signed by the attending<br>page 2 should be detached for use a   | by             | Part II. Other significant conditions   |   |                           | _                       |  | ıse giver                      | in Part I.        |                                      |                           |                           | _             | ause of death?<br>y 4 □Unknown               |   |
| Ö           | w requires been si should be   | eted           | METASTATIC  | LUNG  | CAI                       | NCE                     |  |                                |                   | -                                    | Yes 2[                    |                           |               |  | _ |
| Records,    | sician: The law<br>certificate has t<br>irector, page 2 s  | Completed      | ^ "   | ENAL FI   | 411                       | URE                     | -  |                                |                   | 24a. Was<br>auto<br>perf             |                           | 24b. Were prior to death' | o comple      | findings available<br>etion of cause of      |   |
| Vita        | ificate<br>or, pa  |                | PANCYTOP6 25. Was case referred to medical  | FNIA  |                           |                         |  |                                | OS Plans of Do    | 1  Yes<br>ath (Check only            | 2 No                      | 1 🗆 Ye                    | es 21         | Î No   | _ |
| >           | Physician: The la<br>r this certificate has<br>ral director, page 2  | o Be           | examiner?<br>1 ☐ Yes 2 ☑ No   | Hospital:   | nt 2 🔲                    | ER/Outpatien            | t 3 DOA                                    | Othor                          |                   | difficheck only                      |                           | Other (Sr                 | pecify)       |  | - |
| 0           | ding Ph<br>h.<br>After th<br>funeral   | L:Ľ            | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending   | 28a. Date of Injur<br>(Month, Day   |                           | 28b. Time of<br>Injury  | 280  | c. Injury :<br>Work?           |                   | 28d. Describe                        |                           |                           |               |  | - |
| Sio         | tendii<br>leath.<br>tor: Ay<br>the fu  | catic          | 2 Accident investigat   | ion   |                           |                         | М  | 1 □ Y                          | es 2□No           |                                      |                           |                           |               |  |   |
| Division or | or Att   | Certification: | 4 Homicide determine  |   | ry - At ho<br>:. (Specify | me, farm, stre          | eet, factory,                              | office                         |                   | 28f. Location<br>City or To          | (Street and<br>own, State | d Number or i             | Rural Ro      | oute Number,                                 |   |
| _           | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, grompletely filled in by the funeral director, is   |                | 29a, Certifier 1 Certifying   | Physician: To the best of   | of my know                | wledge, death           | occurred at                                | the time                       | e, date and place | e, and due to the                    | e cause(s)                | and manner                | as state      | d  |   |
|             | n 24 h   | Medical        | (Check only 2 Medical Ex  | aminer: On the basis of<br>and manner sta                                   | examinat                  | tion and/or in          | vestigation, i                             | n my opi                       | nion, death occ   | urred at the time                    | , date and                | place, and d              | ue to the     | e cause(s)                                   |   |
|             | To the within To the comp  | Me             | 29b. Signature and title of certifier   | 2 118   | 1                         | 1111                    |  | License                        |                   |                                      |                           | e signed (Mo              |               |  | - |
|             |  |                | 1///  |   | /                         | Yalist                  | De   | 445                            | 42                |                                      | 07                        | 107                       | 12            | 008  |   |
|             | 4  |                | 30. Name and address of person Wi   |   |                           | 23a) (Type,             | Print)                                     | 01                             |                   | DI                                   | 14                        | 10.1                      | 4.8           | 0 20879                                      |   |
| g.          | Sta  | te             | 31. Date filed (Month, Day, Year)   | ANG-ANA<br>32/Aegistra  | r's Signa                 | ture                    | 7001                                       | J-12                           | KOOWE             | 1 Kg                                 | oal/                      | NK V(3U )                 | S/M)          | 2007   | ~ |
|             | Registr.   | _              |   | 2008  | a A                       | K do                    | 349  |                                |                   |                                      |                           |                           |               | •  | ı |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day **Physician** DOROTHY MAE STREVIG EBRUARY 8:FM 12,2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Saint Joseph Medical Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Davs Hours Min. 1 □ M 2X F 218-32-6471 Director 9/20/1935 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director WESTMINSTER MD CARROLL 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21157 20 SULLIVAN AVE. USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 h (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FORK LIFT OPERATOR MANUFACTURING 12 marked other Junould be filk of the and Mental Hw 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN LEROY STREVIG MARY PRUDENCE BARNHART 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 nt of Health a tilitem 27 is or other trai 20 SULLIVAN AVE., WESTMINSTER, MD 21157 GLADYS BAUERLINE -SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State KRIDER'S CEMETERY 2/16/08 4 ☐ Donation 5 ☐ Other (Specify) WESTMINSTER, MD 21. Si natura f Aral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he are ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC CARCINOMA TO THE LIVER /Medical Due to (or as a consequence of): Examiner LUNG CARCINOMA WITH METASTASES if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ DEHYDRATION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforr 25. Was case referred to medical examiner?

1 ☐ Yes ∠No funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dipatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day or Attending 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) loy M.D. 4 12,2008 DØØ17695 NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MARYLAND M. D. 76.71 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 16a, b per fh 9876 2-14-08 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year **Physician** her 230 7M 0 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howar 6.2 ne/A1 Colum touns'd If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F 183-38-4207 62 Director 01/08/1946 PA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d Inside City Limits "natural", or items 23a or 28a-f show diral Examiner must be notified at 1 □Yes 2 No Director HOWARD MD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7114 LASTING LIGHT WAY 21045 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify à Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 7 is marked other than "natural traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working ENVIRONMENTAL ENVIRONMENTAL Elementary/Secondary (0-12) College (1-4or 5+) 12 SPECIALIST APEX <del>ENVIROMENTAL</del> permit. Pages 1 and 2 should be filler.
Department of Health and Mental Hyak
Important: if item 27 is marked
any Injury or other \*\*\* 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BERNARD SIMMONS BELLE MANNES 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) REBECCA SIMMONS / WIFE 7114 LASTING LIGHT WAY, COLUMBIA, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) MONTEFIORE CEMETERY 02/13/2008 JENKINTOWN, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. REISTERSTOWN ROAD - PIKESVILLE, MD 21208 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1 Enter the disease, of shook, or heart failure. List Immediate Cause (Final Atherosoleona **Physician** NOWNSWIN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1, Des 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform<u>ed</u> or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 21 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Mann of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cartifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tours 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 2008 1:00 A M **SCHILLER** ELIZABETH 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death MONTGOMERY SUBURBAN HOSPITAL BETHESDA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 03/03/1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 M 2 X F °HÜNGARY Yrs 88 218-18-6842 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MD MONTGOMERY **POTOMAC** 1 ☐Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11215 SEVEN LOCKS ROAD, #226 20854 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **JACOB** KOHN SERENA UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11 SLADE AVE., #611, BALTIMORE, MD 21208 JAMES SCHILLER / SON 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 20a. Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 02/11/2008 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licentee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CEREBROVASCULAR DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an DEMENTIA autopsy performed? Yes 2 \textbf{\text{No}} **HYPERTENSION** 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2X No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

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Physician

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**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ ... any injury or other traumatic event.

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Certification: To

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29a. Certifier

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Records,

Vital Physician:

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To the Hospital o within 24 hours aft To the Funeral Di

filled in by the

completely

Completed by Physician/Medical 1 Yes 2 No. 9 Unknown

> 27. Manner of Death 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

> > MO

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) and manner stated 29b. Signature and title of certifier

29c. License number D0063195

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 2/9/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8620 OLD GEORGETOWN ROAD, BETHESDA, MD 32. R. distrar's Signature 31. Date filed (Month,

20814

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month LORETTA SULLIVAN 12 17.55 M 2008 Feb /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL BALTIMORE JOHNS HOPKINS BAYVIEW CENTER Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Days Hours 079-20-7768 79 Director July 6,1928 Brooklyn, NY Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10d. Inside City Limits Examiner must be notified at 1 ☐ Yes 2 📆 No Director Maryland Baltimore Dundalk 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö natural", or Items 23a 21222 U.S.A. 4072 St. Monica Drive within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No If Yes, Give 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. Specify: White þ 3X Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Roman Catholic 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Diocese of Brooklyn Cook 12 years Department of Health and Should be flie Important: If Item 27 is marked other any Injury or other trainment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen McKeon George Ryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4072 St. Monica Drive, Dundalk, Maryland 21222 Daughter Eileen Irish 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 Burial 2 □ Cremation 3 □ Removal from State Calvary Cemetery Woodside, New York 4 ☐ Donation 5 ☐ Other (Specify) 16, 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pneumonia 24 hours disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner dementia unknown Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner executed burial-transi and Due to (or as a consequence of): Box 68760, attending physician for use as the buria certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the at the detached for Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2X No 1 🖺 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 npatient 2 ER/Outpatient 3 DOA ပ After this Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending F safter death. Il Director: After d in by the funera Certification: Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29h. Signature and title of certil medical doctor Res-000

Registrar

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Christine

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31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Johns Hopkins Hospital, 600 North Wolfe Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Durand

Year)

February 12, 2008

Balhmore

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 10:30AM ROBERT I. SAUNDERS 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 18119 YORK RD PARKTON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/18/1920 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min INDIANA 1 X M 2 □ F 310-16-3926 87 Director Usual Residence of Decedent 10c, City, Town or Location 10a. State 10h County 10d Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE PARKTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 18119 YORK RD. 21120 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 XNo Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2YRS ENGINEER ELECTRICAL ENGINEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FREDERICK S. SAUNDERS ELSIE ILES ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVE NYE(SON IN LAW) 18119 YORK RD PARKTON, MD. 21120. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State WASHINGTON PARK 02/11/2008 INDIANAPOLIS, INDIANA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility HENRY W. JENKINS & SONS C 16924 YORK RD MONKTON, MD. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>6</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar page 2 s has autopsy perform 2 No 1 Tyes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one Certification: To Be Other: 4 Nursing Home Hesidence 6 Other (Specify) 20 No 1 ☐ Yes 1 | Inpatient 2 ER/Outpatient 3 DOA this uneral 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Year) Iniury Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: A 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

State Registrar (Check only

29b. Signature and title of certifies

31. Date filed (Month, Day,

address of person who completed cause of death (Item 23a)

32. Registrar's Signature

Year) 1 2008

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the

29c. License number

29d. Date signed (Month, Dav. Year)

|            |  |                | For State Registrar  | State of Ma  |                                 | partment of F<br>ertificate of                                 |                                       | Mental Hy                         | /giene<br>Reg. No.           |   | 3         | 04306                                |
|------------|--|----------------|--|--|---------------------------------|--|---------------------------------------|-----------------------------------|------------------------------|---|-----------|--------------------------------------|
| i.         | Dhynisi  | 20             | 1. Decedent's Name (First, Middle, La  | st) C  |                                 |  |                                       | 2. Date of D<br>Month             | eath                         |   |           | . Time of Death                      |
| ÷          | Physici<br>/Medic  |                | DONNA  |  | HARI                            |  |                                       | OZ                                | Day<br>O'                    | 7 OF  |           | 2145 M                               |
|            | Examin   | er             | 4a. Facility Name (If not institution, giv   | e street and number)                                 |                                 | 4b. City, Town, o  | Location of Dea                       | ath                               | 4c.                          | County of Dea                               | ath       |                                      |
| -          |  |                | 1000 PARK PLACE  5. Social Security Number 6. S  | Sex 4 7 Age  | (In yrs. last birthd            | BALTIMORE<br>av) If Under 1 Year                               | If Under 24 Hr                        | S. 8 Date of B                    | irth                         | 0.8   | irthalase | /Ctnto or Foreign                    |
| b          | Funeral<br>Director  |                |  | M 2 RF   | 45 Yrs                          | Months Days  | Hours Min                             |                                   | ay, Year)<br>27 <b>, 1</b> 9 | 62  | Country)  | e (State or Foreign<br>MD            |
|            | yland<br>low<br>at   |                | 10a. State 10b. County   |  | 10c. City, Town or              | Location   |                                       |                                   |                              |   | 10d.      | Inside City Limits                   |
|            | a-f sh   | Director       | MD   | _  | Baltimore                       |  |                                       |                                   |                              |   |           | 1∏Yes 2□No                           |
|            | or 28  | Dire           | 10e. Street and Number   |  |                                 | 10f. Zip Code  |                                       |                                   | 10g. Citi:                   | zen of What C                               | Country?  |                                      |
|            | ath w  |                | 1000 Park Place  |  |                                 | 21220  |                                       |                                   |                              | USA   |           |                                      |
|            | er de<br>items   | Funeral        | 11. Marital Status   | 12. Was Decedent E<br>Armed Forces?                  | ver in U.S. 1                   | <ol> <li>Was Decedent of H<br/>If Yes, specify Cuba</li> </ol> | ispanic Origin? (<br>an, Mexican, Pue | Specify Yes or Nerto Rican, etc.) | 0-                           | <ol> <li>Race - Am<br/>Black, Wh</li> </ol> |           | ndian,                               |
| 36         | filed within 72 hours after death with the Maryland<br>Hygiene.<br>wther than "natural", or items 23a or 28a-f show<br>ent, the Medical Examiner must be notified at | by F           | 1 ☐ Never Married 2(X) Married 3 ☐ Widowed 4 ☐ Divorced  | 1 ☐ Yes XX № If Yes, Give Year or Dates:             | •                               | 1 ☐ Yes XX No  | Specify:                              |                                   |                              | Specify: 1                                  | ∛hite     |                                      |
| 21215-0036 | 2 hou  | ted            | 15. Decedent's E   | ducation   | 16a. De                         | cedent's Usual Occup   | ation                                 |                                   | 16b. Kii                     | nd of Busines:                              | s/Indust  | ry                                   |
| 7          | thin 7<br>an "n<br>Med   | Completed      | (Specify only highest gra<br>Elementary/Secondary (0-12)   | completed) College (1-4or 5+                         | - life                          | ive kind of work done of<br>e. DO NOT use retired              | 1)                                    | orking                            |                              |   |           |                                      |
| 7          | filed wi<br>Hygier<br>Ither th   | Con            | 12   | 2  |                                 | Office MAnag   |                                       |                                   | 1                            | McComa                                      | as Oi     | 1                                    |
| Maryland   | a la la  | Be             | 17. Father's Name (First, Middle, Last   | ,  |                                 |  | 18. Mother's Na<br>Laura 01           | ame <i>(First, Middl</i>          | e, Maiden                    | Surname)                                    |           |                                      |
| Ĕ          | 2 should<br>and Mer<br>Is marke<br>aumatic   | 은              | Phillip Shears  19a. Informant's Name/Relationship (   | Type Print)  | 19h M                           | ailing Address (Street   |                                       |                                   | har City o                   | r Town State                                | Zin Co    | dal                                  |
|            | es 1 and 2 should to the alth and Menter the 27 is marked rother traumatice  |                | Scott Scharf   | Husband  | Ì                               | 00 Park Place  |                                       |                                   | 1226                         | rown, otate,                                | , 210 000 | 16)                                  |
| ē,         | of Hea   |                | 20a. Method of Disposition   |  | 20b. Place of Dis               | sposition (Name of crematory or other place                    |                                       | Date                              |                              | cation - City o                             | or Town,  | State                                |
| Ē          | Page<br>nent c<br>int: If<br>iry or  |                | 1 ☐ Burial 2 ☒️Sremation 3 ☐<br>4 ☐ Donation 5 ☐ Other (Specif   |  | Bayview C                       |  | 7                                     | 8, 2008                           | Bal                          | timore,                                     | MD        |                                      |
| Baltimore, | permit. Pages 1<br>Department of H<br>Important: If Ite<br>any injury or ot<br>once.   |                | 21. Signature of uneral Service Lice   | M01148   |                                 | 22. Name and Addres  | al Homé, F                            |                                   | MD 0                         | 1061  |           |                                      |
|            | 1000   |                | 23a. Part1. Enter the disease or conshock, in heart failure. ist only  |  | he death. Do not                | 426 Crain I<br>enter the mode of dyin                          |                                       |                                   |                              | 1061  | Ap        | proximate                            |
|            | Physician  |                | Immediate Cause (Final disease or condition  | cause on each line                                   | ( un                            | e:   |                                       |                                   |                              |   | 180       | erval Between<br>set and Death       |
|            | /Medical   |                | resulting in death)  | a. Due to (or as a                                   | consequence of):                |  |                                       |                                   |                              |   | 10        | 17/010/1/15                          |
|            | Examiner   |                | Sequentially list conditions   | b  |                                 |  |                                       |                                   |                              |   |           |                                      |
|            | ait sit  | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying                                   | Due to (or as a                                      | consequence of):                |  |                                       |                                   |                              |   |           |                                      |
| E.         | and<br>and<br>II-tran  | Examiner       | that initiated events resulting in death) Last   | c<br>Due to (or as a                                 | consequence of):                |  |                                       |                                   |                              |   |           |                                      |
| P8/P0      | tificate be executed<br>g physician and<br>as the burial-transit   |                |  | ď  | , ,                             |  |                                       |                                   |                              |   |           |                                      |
| ĝ          | tificate<br>ig phy<br>as the   | ledical        |  | 50.  |                                 |  |                                       |                                   |                              |   |           |                                      |
| go         |  | Physician/N    | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome p                               |                                 | 3 □Ectopic pregnancy   |                                       |                                   | 2                            | 23d. Date of de                             |           |                                      |
| 5          | e dea<br>the att   | sici           | in the past 12 gonths?<br>1 □ Yes 2 □ No<br>9 □ Unknown  | 4□Pregnant at t<br>9□Unknown                         |                                 | 5 Other (specify)  |                                       |                                   |                              | Month                                       | Day       | / Year                               |
| 7          | hat the default  | Phy            | Part II. Other significant conditions  |  | not reculting in the            | a underlying cause give  | on in Part I                          | 23a Did                           | tobaccou                     | co contributo                               | to the e  | ause of death?                       |
| cords,     | w requires that the death cer<br>been signed by the attendir<br>should be detached for use   | ed by          | Tack Significant conditions  |  | . Hot resulting in the          | e underlying cause givi  | en in Fait i.                         |                                   |                              |   |           | 4 □Unknown                           |
| ပ္ထ        |  | Completed      | <del></del>  |  |                                 |  |                                       | 24a. Was                          | s an<br>opsy                 | prior to                                    | o comple  | findings available etion of cause of |
| E          | siclan: The law certificate has birector, page 2 s   | S              |  |  |                                 |  |                                       | perl<br>1□ Yes                    | omed?<br>2514o               | death?                                      | s 2       |                                      |
| VItal      | siclan<br>certifi<br>rector  | Be             | 25. Was case referred to medical examiner?   | Hospital:  |                                 | tiont 2004 Othe  | or:                                   | eath (Check only                  |                              |   |           |                                      |
| 0          | Physer this eral di  | <u>۲</u>       | 1 ☐ Yes 2 No<br>27. Manner of Death  | 1 ☐ Inpatien<br>28a. Date of Injury                  | t 2 ER/Outpat                   | tient 3 DOA  | 4 ∐ Nursing                           | Home 5 Res                        |                              |   | ecify)    |                                      |
| 0          | ndlng<br>th.<br>r: Afte<br>e fune  | tion           | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation   | (Month, Day  | Year) Injur                     |  | k?<br>Yes 2 ∐ No                      |                                   |                              |   |           |                                      |
| UNISION    | or Atte  | Certification: | 3 Suicide 6 Could not be determined  | 28e. Place of injur<br>building, etc.                | y - At home, farm,<br>(Specify) | street, factory, office  |                                       | 28f. Location<br>City or To       | (Street and<br>own, State)   | d Number or F                               | Rural Ro  | ute Number,                          |
| _          | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director.    | ledical Ce     | 29a. Certifier 1 Certifying Ph   | nysician: To the best of<br>niner: On the basis of o | my knowledge, de                | eath occurred at the tin                                       | ne, date and pla                      | ce, and due to the                | e cause(s)                   | and manner a                                | as state  | d.                                   |
|            | thin 2<br>the l  | Medi           | one)   | and manner etat                                      | nd                              |  |                                       |                                   |                              |   |           | ' '                                  |
| )          | ₹. <u>₹</u> .₹.8   | =              | AAA (a)  | til in   | 1                               | T)   | 1.142                                 | 5                                 | John Jak                     | a signed (Mon                               | ıııı, Day | 18 ) AND                             |
| ,          | 7 7  | -              | 30 Name and address of person who  | completed cause of dea                               | ath (Item 23a) (Typ             | Print)   | 11                                    | ا د                               | 1                            | vuar  | 1/10      | 15,000                               |
|            | [  |                | 29b. Signature and titleron certifier  30 Name and address of person who  31. Date filed (Month, Day, Year)  FEB 1 4 | VENA W   | 's Signature                    | DEKENSE  | MIGH                                  | tway 1                            | HOVEN                        | APOLIS                                      | WID       | 12/40)                               |
| 9          | Sta<br>Registr   | te<br>ar       | FEB 14   | 2008   | and the                         | Sports   |                                       |                                   |                              |   |           |                                      |

|                   |   |                | For<br>State<br>Registrar   | State             | of Marylan  |                                      | artment of H<br>rtificate of  |  |                                       | giene<br>Reg. No. 20         | 08                           | 0430   | 7 |
|-------------------|---|----------------|---|-------------------|---|--------------------------------------|---|--|---------------------------------------|------------------------------|------------------------------|--|---|
| in the second     | Physicia<br>/Medic  |                | 1. Decedent's Name (First, Middle,  | Last)             | SAL   | - IV                                 | A   |  | 2. Date of Dea<br>Month<br>02         | Day<br>06                    | Year                         | 3. Time of Death                             |   |
| ,                 | Examin  | Serve III      | 4a. Facility Name (If not institution, g  |                   | imber)  |                                      | Glen Burn   |  | h                                     | 4c. County                   |                              |  |   |
|                   | Funeral<br>Director   |                | 5. Social Security Number 6 214-42-4934 Usual Residence of Decedent   | Sex<br>1□ M 2√F   | 7. Age (In yrs. 77  | last birthday)<br>Yrs.               | If Under 1 Year<br>Months Days  | If Under 24 Hrs<br>Hours Min.                        | (Month, Day                           | h<br>/, Year)<br>2-1930      | 9. Birthpl<br>Count          | ace (State or Foreigr<br>ry)<br>France       | ) |
|                   | Maryland<br>a-f show<br>ified at  | ctor           | 10a. State 10b. County  MD Anne Are   | undel             |   | y, Town or Lo                        |   |  |                                       |                              | 10                           | od. Inside City Limits  1 ☐ Yes 2 ☐ No       |   |
|                   | ath with the<br>s 23a or 28<br>sust be not  | ral Director   | 10e. Street and Number 307 MacKintosh Driv  |                   |   |                                      | 10f. Zip Code   | 21061  |                                       |                              | USA                          |  |   |
| 5-0036            | 72 hours after death with the Marylan<br>"natural", or Items 23a or 28a-f show<br>sdical Examiner must be notified at   | by Funeral     | 11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced  | Armed F           | ive No  |                                      | Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes 2(X) No               | dispanic Origin? (S<br>an, Mexican, Puer<br>Specify: | Specify Yes or No-<br>to Rican, etc.) | Specil                       | ce - America<br>ck, White, e | etc.   |   |
| 0-6121            | should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show marked other than "natural", or Items 23a or 28a-f show imatic event, the Medical Examiner must be notified at | Completed      | 15. Decedent's<br>(Specify only highest<br>Elementary/Secondary (0-12)  | grade completed,  | )<br>(1-4or 5+)   | 16a. Dece<br>(Give<br>life.          | dent's Usual Occup<br>kind of work done<br>DO NOT use retire<br>Homemaker | pation<br>during most of wo<br>d)                    | rking                                 | 16b. Kind of B               |                              | ustry  |   |
| Maryland 2        | lid be filed view lental Hygie<br>ked other is event, the   | To Be Co       | 17. Father's Name ( <i>First, Middle, La</i><br>Said Hadad  | ast)              |   |                                      | nomemaker   |  | me <i>(First, Middle,</i>             | Maiden Surnai                | Home<br>me)                  |  |   |
| _                 | as 1 and 2 should to Health and Ment item 27 is marked rother traumatic   |                | 19a. Informant's Name/Relationship<br>Syvia Cueva   | o (Type. Print)   |   | 6442                                 | ng Address <i>(Street</i><br>Continenta                                   | and Number or R                                      | ural Route Numbe                      | er, City or Town             |                              |  |   |
| Baltimore,        | permit. Pages 1 Department of H Important: If itel any Injury or ott  |                | 20a. Method of Disposition  1 ⊠Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe  21. Sign turn Funeral Service Li        | ecify)            | State   | emetery, cre<br>wns∨ill              | osition (Name of matory or other pla                                      | Cem Feb  |                                       | 20c. Location<br>Crownsvil   | ,                            | wn, State                                    |   |
| Ва                | permi<br>Depa<br>Impo<br>any li   | 1              | 21. Sign targer Fundral Service Li<br>"K. Gregory Fink<br>23a. Part Enter the disease, one<br>shock or heart fakure, List o | M01148            | caused the deat   |                                      |   | Hwy S., G  | len Burnie                            |                              | 1                            | Approximate                                  |   |
|                   | Physician<br>/Medical   |                | shock or heart favure.) List of<br>Immediate the se (Final<br>disease or con-lition<br>resulting in death)                  | _a //             | each line.  | nence of):                           | Typen   | RCTUR  | RE                                    | ZONT                         |                              | Interval Between<br>Onset and Death<br>2 MOS |   |
|                   | Examiner  | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                 | b. Due to         | i (Ui as a CUliseq  | uence of).                           | GPEN  | TENSIO   | N                                     |                              |                              | years  |   |
| 8760,             | icate be executed<br>physician and<br>s the burial-transit  | dical Examiner | that initiated events<br>resulting in death) Last   | c                 | (or as a conseq   | uence of):                           |   |  |                                       |                              |                              |  |   |
| O. Box 68         | eath certil<br>attending<br>for use a   | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown                                     | 1 ☐Live           | utcome pf pregna<br>birth 2  Feta<br>gnant at time of d<br>nown | al death 3                           | ⊒Ectopic pregnanc<br>⊒ Other (specify) _                                  | у  | 7                                     |                              | ate of delive                | ry<br>Day Year                               |   |
| rds, P            | w requires that the d<br>been signed by the<br>should be detached   |                | Part II. Other significant condition  | s contributing to | death but not res   | ulting in the L                      | underlying cause gi   | ven in Part I.                                       | 23e. Did to                           | v                            | ntribute to th               | e cause of death?<br>ably 4 Dunknowr         | 1 |
| al Records,       |   | Completed by   | onemia  | <u>د</u>          |   | 419.91                               |   |  | 24a. Was<br>autor<br>perfo<br>1∐ Yes  |                              | prior to cor<br>death?       | osy findings available inpletion of cause of | ) |
| Division or Vital | this ald  | ation: To Be   | 25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investiga                  | 28a. Date<br>(Mo  | Inpatient 2<br>e of Injury<br>nth, Day Year)                    | ER/Outpatie<br>28b. Time o<br>Injury | of 28c. Inju  | ner: 4 🗆 Nursing                                     | Home 5 Resid                          | dence 6 □Ot                  |                              | )  |   |
| DIVIS             | ital or Atte<br>irs after dec<br>ral Directo<br>led in by th  | Certification: | 3 ☐ Suicide 6 ☐ Could no<br>4 ☐ Homicide determin   | 20e. Flat         | ee of injury - At ho<br>ding, etc. (Specil                      | ome, farm, st                        | reet, factory, office   |  | 28f. Location (S<br>City or Tox       | Street and Num<br>vn, State) | ber or Rura                  | l Route Number,                              |   |
|                   | To the Hospital or Attending F<br>within 24 hours after death.<br>To the Funeral Director: After<br>completely filled in by the funer   | Medical        |   | xaminer: On the   |   |                                      | th occurred at the t<br>nvestigation, in my<br>29c. Licen:                | opinion, death occ                                   | curred at the time,                   |                              | e, and due to                | the cause(s)                                 |   |
| )                 | ± ≥ ± δ   |                | M Charl 30. Name and address of person;   | f or moleted car  | enta<br>use of death (Item                                      | W)                                   |   |  |                                       |                              |                              | 08,2008<br>SMD 2140                          |   |
|                   | Sta   | ite_           | MICHAEL J. ( 31. Date filed (Month, Day, Year)  | a ENT             | A W) Registrar's Signa  | 441                                  | DEFEN   | ISE H  | 16HWA                                 | y ANN                        | A POLI                       | SMAZIYO                                      | 1 |
|                   | Registr   | ar             | FEB 14  | 2008              | BAS &   | To and the                           | 1   |  |                                       |                              |                              |  |   |

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UUS 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 30 AM Areatha C. Terry 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Northwest Hospital Center Randallstown Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

70 Yrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Mar 24, 1928 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number **Funeral** 1 □ M 2 🗙 F 79 Yrs. 216-28-1922 Director Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exemples must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Baltimore **Funeral Director** Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6325 Monika Place Apt. 512 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: δ 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Catlege (1-4or 5+) Nursing Technician Hospital 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Nelson Smith Beatrice Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4303 Travancore Court Randallstown, Maryland 21133 Rodney Terry, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metro Crematory Inc. 02/13/08 Baltimore, Maryland 21. Signature of Funeral Service Liberson Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** YUCCR /Medical Due to (or as a consequence of): Examiner nKorson Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as a consequence of): Examine signed by the attending physician and I be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Z No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed. 1∐ Yes 2/2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2☑No 1 ☐ Inpatient 2 Z ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day Year) 28b. Time of Injury Certification; 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

State Registrar 31. Date filed (Month, 'Day, Year) 2008

803

12.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Sen



29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Amend #30, perDVR, g876, 2/14/08 TCertificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** NANCY CHANCELLOR TILTON FEB. 2008 /Medical 5 3:58A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7834 Babikow Rd. Baltimore County Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M **X2X**□ F Director 218-46-4928 60 Sept. 21,1947 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Directo Maryland Baltimore Baltimore County 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7834 Babikow Rd. 21237 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 3 No If Yes, Give Year or Dates: 1 ☐ Never Married 🎗 🔀 Married White 1 ☐ Yes 2 No Specify: Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore County 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) 2 yrs. Circuit Court Jury Commissioner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert D. Chancellor Carrie L. Babikow ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7834 Babikow Rd. Baltimore, Md. 21237 Kenneth L. Tilton (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐Removal from State 2-9-2008 Baltimore, Md. Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lidensee Lassahn Funeral Home No 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner x24303 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burlal-transit and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cancer 1 TYes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Hospital: 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) C 3 Ken 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Daniel Hugh Collector, MD Timonium, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 3 5 B FEB 2008 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Brow Tilton

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2 P M LIPTON february RILLY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR BALTIMORE HUSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Jan. 11, **Funeral** Birthplace (State or Foreign Country) Year. 1**X** M 2□ F Months Days Hours 414-58-4209 67 Director TN Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 8553 Neptune Drive 21122 U.S.A. Funeral ural", or Items 2 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: if item 27 is marked other than "natural", or ite ury or other traumatic event, the Medical Examinearury 1 ☐ Yes 2 📉 No If Yes, Give 1 ☐ Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Specify: White 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Painter Dukes Painting Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Edward Tipton Willie Cathey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Florenda Tipton/Wife 8553 Neptune Drive Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of h Important: If ite any Injury or of eb 2008 16, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Glen Haven Mem. Park 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funeral Service Licenses 2000918 Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LUNG CANCER 5 Months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-transi Due to (or as a consequence of): physician Physician/Medical attending p IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖔 No Day 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should be Emphysema 1 Yes 2 No 3 Probably 4 Unknown Paroxysmal Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 📉 No 24a. Was an has Hypertension performe certificate 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No ျ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

Division or Vital Records, P.O. Box 68760,

e Hospital or Attending Physician: 24 hours after death.
e Funeral Director: After this certificalety filled in by the funeral director, p To the Hospital within 24 hou To the Fune completely fi

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID Van Echo, 3001 South Hanover Street, BALTIMORE, MARYLAND 31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

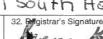
Medical

4 Homicide

(Check only one)

29b. Signature and title of pertific

FEB



2008



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

MAR Physician

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated,

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D24532

28f. Location (Street and Number or Rural Route Number, City or Town, State)

february

29d. Date signed (Month, Day, Year)

11 2008

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|            |  |                | 1 - For<br>State<br>Registrar   | State of Ma  | aryland / Depi<br><i>Ce</i>                               | artment of r<br>rtificate of                              |  | •  | giene<br>Reg. No. | 008   | 043                             | 12                   |
|------------|--|----------------|---|--|---|---|--|--|-------------------|---|---------------------------------|----------------------|
|            |  |                | Decedent's Name (First, Middle, La  | st)  |   |   |  | 2. Date of De                                |                   | Year  | 3. Time of I                    | Death                |
|            | Physici<br>/Medic  |                | MARTHA ALICE THOMAS   |  |   |   |  | Month<br>FEB. 5,                             |                   | T ear                                       | 1158                            | рм                   |
|            | Examin   |                | 4a. Facility Name (If not institution, given  |  |   | 4b. City, Town, o   | or Location of Death                                     |  | 4c. Cc            | ounty of Death                              |                                 |                      |
|            |  |                | ST. CATHERINES NURSIN   |  |   | EMMITS  |  |  |                   | FREDERICK                                   |                                 |                      |
|            | Funeral<br>Director  |                | 220.56.0183   | Sex 7. Ag  | 92 Yrs.   | If Under 1 Year<br>  Months   Days                        | If Under 24 Hrs.<br>Hours Min.                           | 8. Date of Bir<br>(Month, Da<br>AUG 14       |                   | 9. Birth                                    | place (State or<br>ntry)<br>MD  | Foreign              |
|            | land<br>W  |                | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Town or Lo                                     | ocation   |  |  |                   |   | 10d. Inside City                | y Limits             |
|            | Many<br>-1 sh  | to             | MD FREDERICK  |  | EMITTSBU  | JRG   |  |  |                   |   | 1 ☐ Yes                         | X⊠ No                |
|            | r 28g  | Director       | 10e. Street and Number  |  |   | 10f. Zip Code   |  |  | 10g. Citíze       | n of What Cou                               | ntry?                           |                      |
|            | th wit   |                | 331 S. SETON AVE.   |  |   | 2172  | 7  |  | US                | SA  |                                 |                      |
| 21215-0036 | hours after death with the Maryland<br>tural', or itame 23a or 28e-1 show<br>at Exemicer must be notified at | by Funeral     | 11. Marital Status  1 Never Married 2 Married  XX Widowed 4 Divorced  | 12. Was Decedent<br>Armed Forces?<br>1 ☐ Yes XX☐<br>If Yes, Give<br>Year or Dates: | No  | Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes ※※ No | dispanic Origin? (Spe<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No<br>Rican, etc.)              | }                 | Race - Amen<br>Black, White,<br>pecify: WHI | etc.                            |                      |
| 2-0        | 72 hours<br>natural',<br>dical Exe   | etec           | 15. Decedent's E<br>(Specify only highest gr  | ducation<br>ade completed)   | (Give   | dent's Usual Occup<br>kind of work done                   | during most of worki                                     | ing  | 16b. Kind         | of Business/In                              | dustry                          |                      |
| 12         | d within 72 ho<br>piene.<br>r than "natur<br>Ine Medical   | Completed      | Elementary/Secondary (0-12)   | College (1-4or   | life  | DO NOT use retire   | d)   |  |                   |   |                                 |                      |
|            | filed v<br>Hygie<br>other t  | e Co           | 17. Father's Name (First, Middle, Last  | )  |   | HOMEMAKER   | 18. Mother's Name  | (First, Middle                               |                   | NN HOME                                     |                                 |                      |
| an         | ed la b  | To Be          | GEORGE W. KING  | •  |   |   | MARY M. AR   |  |                   |   |                                 |                      |
| Maryland   | 2 should<br>and Men<br>le marke<br>aumatic   | -              | 19a. Informant's Name/Relationship  | Type, Print)   | 19b. Maili  | ng Address (Street  | and Number or Rura                                       | al Route Numb                                | er, City or 7     | Town, State, Zij                            | Code)                           |                      |
|            | and 2<br>saith a<br>n 27 le  |                | MARY ANNA MYERS   | DAUGHTE  | R 4580 F  | RANCIS SCO  | TT KEY HWY,  | TANEYTOW                                     | N, MD             | 21787                                       |                                 |                      |
| Baltimore, | of Her   |                | 20a. Method of Disposition  1   → Surial 2 □ Cremation 3 □  → 4 □ Donation 5 □ Other (Speci   |  | -   | matory or other pla                                       | сө) CARDENS FEB  | 8,2008                                       |                   | ation - City or T                           | ·                               |                      |
| Balti      | permit. Page<br>Department of<br>Important: if<br>any injury or<br>once.                                     |                | 21. Signar re of uner I Servic. Lic   |  | 2 2 F   | 2. Name and Addre   | ess of Facility<br>L HOME, P.A.                          | in the                                       |                   | 21061                                       |                                 |                      |
|            |  |                | 23a. Part1. Exter the disease, or con<br>shock, or heart failure. List on   |  |   |   |  |  |                   | 21001                                       | Approximate<br>Interval Betw    | 3                    |
|            | Pnysician<br>/Medical  |                | Immediate Cause (Final disease or condition resulting in death)   | a Zna  | a consequence al:   | e Al  | The  | rect   | +                 | ,   | Onset and D                     | Death                |
|            | Examiner   | e              | Sequentially list conditions, 1 any, leading to immediate   | b. The to (or as   | a eonsaquence of)   | 1-  | 1500   |  | one               | 1   | 12 y                            | grs                  |
|            | tificate be executed is physician and as the burial-transit  | Examiner       | Sequentially list conditions, it any, leading to him cluste cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as   | a consequence of):  | Sus/  | U.   |  |                   | /   | 12 Th                           | 2                    |
| 68760,     | siciar<br>b buria  | caiE           |   | d  |   |   |  |  |                   |   |                                 |                      |
| 687        |  | edicai         |   |  |   |   |  |  |                   |   |                                 |                      |
| .O. Box    | death cer<br>e attendir<br>d for use   | Physician/M    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown                          | 2 Fetal death 3   | □Ectopic pregnanc<br>□ Other (specify) _                  | у  |  | 230               | d. Date of deliv<br>Month                   |                                 | 'ear                 |
| rds, P     | quires that<br>n signed b<br>uld be deta   | by             | Part II. Other significant conditions   | contributing to death b  | ut not resulting in the u                                 | inderlying cause giv                                      | ven in Part I.   |  | tobacco use       | ocontribute to t<br>No 3 ☐ Pro              | the cause of debably 4 Du       |                      |
| Records,   | The law requires that the ate has been signed by the page 2 should be detache                                | Completed      |   |  |   |   |  | 24a. Was<br>auto<br>perfo<br>1 \(\sum \) Yes |                   | death?                                      | opsy findings a ompletion of ca | available<br>ause of |
| Vital      | certifica<br>rector, p   | Be C           | 25. Was case referred to medical examiner?  |  |   |   | 26. Place of Death                                       | (Check only                                  | one)              |   |                                 |                      |
| of V       | 80 S =   | မ              | 1 ☐ Yes 2 XNo   |  | ent 2 ER/Outpatie   |   | Nursing Ho   |  |                   | Other (Speci                                | fy)                             |                      |
| o Li       | ding Phy<br>th.<br>After this<br>funeral   | iuo!           | 27. Manner of Death  1 ☑Natural 5 ☐ Pending   | 28a. Date of Inju<br>(Month, Da  | y Year) 28b. Time o                                       | Wo  | rk?  | 28d. Describe                                | how injury o      | occurred                                    |                                 |                      |
| Sic        | Attanding<br>r death,<br>actor: After<br>by the fune   | icat           | 2 Accident investigation 3 Suicide 6 Could not be   | e One Blees of Ini   | une At homo form of                                       |   | Yes 2 □No  | 39f Location /                               | Stroot and I      | Number or Rur                               | al Pouto Numi                   | hor                  |
| Division   | ital or Attan<br>irs after deat<br>ral Diractor;<br>led in by the  | Certification: | 4 Homicide determined   | building, et   | ury - At home, farm, st<br>c. (Specify)                   |   |  | City or To                                   | wn, State)        |   |                                 | J6/,                 |
|            | To the Hospital or Attan within 24 hours after deat To the Funaral Diractor: completely filled in by the     | Medicai        | (Check only 2 Medical Exa   | nysician: To the best<br>miner: On the basis o<br>and manner st                    | of my knowledge, deat<br>f examination and/or in<br>ated. | vestigation, in my  | ppinion, death occurr                                    | and due to the<br>ed at the time,            | date and pl       | lace, and due t                             | to the cause(s)                 | )                    |
| )          | To To com  | Σ              | 29b. Signature and title of certifier   | 1/ptrous   | Rel-PC4   | 29c. Licens   | to et t  | 03>  | 29d. Date s       | signed (Month,                              | · Zco                           | }                    |
| 2          | 1  |                | 30. Name and address of person who  | completed cause of   | eath (Item 23a) (Type,                                    | Print)  | 121  | 103  | s w.              | Mice  | in S                            | 3                    |
|            | <u> </u>   |                | Boural. K.  | 2 Eugh   | EC-101  | YICI  | DOE  | Jui  | wit               | 1540  | J. M                            | KOK-                 |
|            | Sta<br>Registr   |                | 3T. Date filed (Month, Day, Yeak)<br>FEB 1 4  | 2008 32. Registr   | ar's Signaturo  | 38492   |  |  |                   |   | 0-2/!                           | 19                   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- state Amend #12 perFH, 23e, perMD, g877 3/16 Painteate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month ores 02 0 0233AM Zas /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sa 16220 5. Social Security Number Age (In yrs. last birthda If Under 24 Hrs. 8. Date of Birth **Funeral** 08/27/1946 Days Hours 1**X** M 2□ F Director 149-36-3076 61 NJ Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment: If item 27 is marked other than "natural; or items 23a or 28a-f show any Injury or rother traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo ROANE TN OAK RIDGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 WESTVIEW LANE 37830 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No TAM If Yes, Give VIETNAM Year or Dates: 1965–1971 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) **ENGINEER** NUCLEAR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill iment of Health and Mental Hiant: If item 27 is marked other. Be **GEORGE** VOREES MARY CECELIA DOMKOFSKI ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA VOREES / WIFE 102 WESTVIEW LANE, OAK RIDGE, TN 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State HILLTOP SERVICE CORP. 02/12/2008 4 ☐ Donation 5 ☐ Other (Specify) TOWSON, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conseque) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the conditions in death). Due to (or as a consequence of) Examine death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) should be detached 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Dotably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1√0 ٩ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 4

21

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

2008 Jane & Agree

30. Name and address of person whe completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend 7&8 perFH, g876, 2/19/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 11, 2008 11:06 A M HAR February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) 1946 1**25**M 2□F Davs Months Hours Min. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 ✓ Yes 2 ☐ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö . Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Itea ury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No þ Baltimore, Maryland 21215-003 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AMPORTS VRS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SE 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or c 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ◆ □Donation 5 □ Other (Specify) e of Funeral Service Licensee Signati 23a / art1. Enter the disease, or complications that caused the death shock, of heart failure. List only one cause on each line. In mediate cause (Final disease or condition resulting in death) Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) burial P.O. Box 68760. physician Physician/Medical the ! as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. Completed by 2 No 3 Probably 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform rector, page 2 or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes PS Medical Certification: To 1 🔲 Inpatient ER/Outpatient 3 DOA this 27. Mariner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural

Accident (Month, Ďay Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital rtifying Physician o the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier on the b-sis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and man per stated. (Check only ☐ Medical Examiner: onel 29b. Signature 29c. License number 29d. Date signed (Morth, Day, Year) 30. Name an IN. Charles St. Towson, Maryland 31. Date filed (Month, Day, Year) State FEB Registrar

|  |                  | For State Registrar  1. Decedent's Name (First, Middle, Last)   | State of Maryland / D   | Certificate of   | Death                                   | Reg.<br>2. Date of Death                        | No. 3. Time of Dea   |
|--|------------------|---|---|--|---|---|--|
| Physicia<br>/Medica<br>Examine   | al               | ALEXUS KENSHAE  4a. Facility Name (If not institution, give s   |   | 4b. City, Town, o  | r Location of Death                     | Month<br>February                               | Day Year 7:47 ]  |
| Funeral<br>Director  |                  | Greater Baltimo: 5. Social Security Number   6. Sex   1 □  Usual Residence of Decedent  | 7. Age (In yrs. last birth  |  | Hours Min.                              | 8. Date of Birth<br>(Month, Day, Ye<br>February | 1,2008 MD  |
| r 28a-f show<br>notified at  | Director         | 10a. State         10b. County           MD         BALTIMORE           10e. Street and Number  | 10c. City, Town   | or Location  |   | 10g.  | 10d. Inside City Lin 1 ☐ Yes 2 ₹ Citizen of What Country?                          |
|  | Funeral D        | 3003 BATAVIA AVE  11. Marital Status  1   Never Married 2   Married 1   Married 2   Married 2   | 2. Was Decedent Ever in U.S.<br>Armed Forces?<br>1 ☐ Yes 27XNo  | 2.1.2<br>13. Was Decedent of H<br>If Yes, specify Cuba                                 | lispanic Origin? (Span, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)                | USA  14. Race - American Indian, Black, White, etc.                                |
| "natur   | Completed by     | 3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade   | completed)  | 1 ☐ Yes 2 ☒ No  Decedent's Usual Occup Give kind of work done life. DO NOT use retired | Specify: sation during most of works    | ing 16t   | Specify: BLACK  b. Kind of Business/Industry                                       |
| o o oth  | Be               | Elementary/Secondary (0-12)  O  17. Father's Name (First, Middle, Last)   | College (1-4or 5+)  | INFANT   |   | e (First, Middle, Maid                          |  |
| realth and Men<br>tem 27 is marke<br>other treumatic                                       | P                | PAUL  19a. Informant's Name/Relationship (Tyr.  GB/N.C. PATHOLOGY)  | WHETSTONE De, Print) 19b.   | Mailing Address (Street  |   | al Route Number, Ci                             | MCQUAY ity or Town, State, Zip Code)  2, ZIZOY,                                    |
| 0  |                  | 20a. Method of Disposition  1 Burial 2 Cremation 3 Re '4 Donation 5 Other (Specify)   | emoval from State   | Disposition (Name of r, crematory or other place)                                      | 02/0                                    | 0ate 200<br>8/2008 (                            | 39470. CTY M   |
| Department Important: I any injury o once.   |                  | 21. Signature of Funeral Service Liennse  23a. Part1. Enter the disease, or complic shock, or heart failure. List only on   |   | 22. Name and Addre   | way the                                 |   | Z////.  Approximate Interval Between   |
| ysician<br>Medical<br>aminer   | Examiner         | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury | Extreme P Due to (or as a consequence o   | rematurit  | y (43                                   | io gnoms  | Onset and Deat   |
| sicia<br>bur   | a                | that inflated events resulting in death) Last   | Due to (or as a consequence o   | f):  |   |   |  |
| ed by the attending phys<br>detached for use as the  | Physician/Medic  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _  | <i>'</i>                                |   | 23d. Date of delivery<br>Month Day Year  |
| eugne<br>pe q  | ۾                | Part II. Other significant conditions con   | tributing to death but not resulting in   | the underlying cause giv   | en in Part I.                           | 23e. Did tobac                                  | co use contribute to the cause of death  |
| rthis certificate has braid director, page 2 st  | e Completed      | 25. Was case referred to medical  |   |  | 26 Place of Deat                        | 24a. Was an autopsy performed 1 Yes 2 1         | 24b. Were autopsy findings avair prior to completion of cause death? No 1 Yes 2 No |
| 0 0  | ation: To B      | examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation   | ospital: 1 Inpatient 2 ER/Out 28a. Date of Injury (Month, Day Year) In                                    | me of 28c, Injur   | er: 4 🗆 Nursing Ho                      |   | e 6 ⊡Other (Specify)<br>injury occurred  |
| within 24 hours after death.  To the Funeral Director: Att completely filled in by the fun | i Certification: | 3 Suicide 4 Homicide 6 Could not be determined  | 28e. Place of Injury - At home, far building, etc. (Specify)  |  |   | City or Town, S                                 |  |
| n 24 h<br>he Fur<br>pletely  | Medicai          |   | er: On the basis of examination and and manner stated.  | Vor investigation, in my c   | ppinion, death occur<br>se number       | red at the time, date                           |  |
| To t   |                  | 1 6 1   | - 1   |  | 52293<br>W, MD                          | - 1   | 2-1-08   |

|   |                  |   | Please  | Type or Prin                                    |                               |                      |   |   |                                 |             | egible.                      |   |
|---|------------------|---|---|---|-------------------------------|----------------------|---|---|---------------------------------|-------------|------------------------------|---|
|   |                  | For State   |   | State of Ma                                     | aryland                       |                      |   | lealth and N                                | lental Hy                       | giene       |                              |   |
|   | -                | State     Registrar     Decedent's Name   | e (First Middle 1s                                    | et)   |                               | Cei                  | rtificate of                              | Death                                       | 2. Date of Dea                  | Reg. No.    | 2008                         | 2 Time at Bright                                |
| Physici   |                  |   | onald Pau   | ·   |                               |                      |   |   | Month                           | Day         | Year                         | 1 In SO P M                                     |
| /Medio<br>Examir  |                  |   |   | re street and number)                           |                               |                      | 4b. City, Town, o                         | r Location of Death                         | Januari                         | ( T         | 2068<br>County of Deatl      | 10:50 P M                                       |
|   |                  |   |   | ty Hospita                                      | 1                             |                      | Hagei                                     | rstown                                      |                                 |             | Washin                       | aten  |
| Funeral   |                  | 5. Social Security N  |   | Sex 7. Age                                      | e (In yrs. las                | t birthday)<br>Yrs.  | If Under 1 Year<br>Months Days            | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birt<br>(Month, Da   | h           | 9. Birti                     | nplace (State or Foreign<br>untry)              |
| Director  |                  | 503-42-80<br>Usual Residence of   | 120   | AX -  | 69                            | 115.                 |   |   | May 3,                          | 1938        | Sout                         | th Dakota                                       |
| laryland<br>show<br>ed at   |                  | 10a. State  | 10b. County   |   | 10c. City, 1                  |                      |   |   |                                 |             |                              | 10d. Inside City Limits                         |
| 72 hours after death with the Maryland<br>natural", or Items 23a or 28a-f show<br>sical Examiner must be notified at  | Director         | Md.   |   | ngton   | <u> </u>                      | Sm                   | ithsburg                                  |   |                                 |             |                              | 1 □ Yes 2 🔀 No                                  |
| with the  |                  | 10e. Street and Nut   | mber<br><b>ange</b> Plo                               | ssom Ct   |                               |                      | 10f. Zip Code                             | 27722                                       |                                 | 10g. Citize | en of What Co                | untry?  |
| leath<br>ns 23<br>must  | Funeral          | 11. Marital Status  | ange F10  | 12. Was Decedent I                              | Ever in U.S.                  | 13.                  | Was Decedent of H                         | 21783                                       | ecify Yes or No                 | . 11        | U.S.A<br>4. Race - Amer      | ican Indian.                                    |
| after o   |                  |   | ied 2 Married   | Armed Forces?<br>1 ☐ Yes 2 ☐ N<br>If Yes, Give  | No                            |                      |   | dispanic Origin? (Sp<br>an, Mexican, Puerto | Rican, etc.)                    |             | Black, White                 |   |
| ural",  | d by             | 3 Widowed   | 4 ☐ Divorced  | Year or Dates:                                  | 04-00                         |                      | 1 ☐ Yes 2 ☐ No                            | Specify:                                    |                                 |             | Specify:                     | White   |
| n 72 hours<br>"natural",<br>edical Exe  | Completed        | (Spec   | 15. Decedent's E<br>cify only highest gr              | ducation<br>ade completed)                      | 1                             | 16a. Dece<br>(Give   | dent's Usual Occup kind of work done      | oation<br>during most of work<br>d)         | king                            | 16b. Kin    | d of Business/I              | ndustry   |
| within ene.   | dwo              | Elementary/Seco   | ondary (0-12)   | College (1-4or 5                                | i+)                           |                      | mptroller                                 | •   |                                 | G           | overnme                      | nt  |
| e filed<br>al Hyg<br>other  | Be C             | 17. Father's Name   | (First, Middle, Las                                   |   |                               |                      | "DCTOTTET                                 | 18. Mother's Nam                            | e (First, Middle,               |             |                              |   |
| Menta<br>Menta<br>arked   | To               | Ralph   | D. Brown  | n   |                               |                      |   | Alma  | a Larson                        | 2           |                              |   |
| 12 shown and 71s m  |                  | 19a. Informant's Na   | •   |   |                               | 19b. Mailii          | ng Address (Street                        | and Number or Rui                           | ral Route Numbe                 | er, City or | Town, State, Z               | lip Code)                                       |
| Pages 1 and 2 should be filed within 72 ho<br>nent of Health and Mental Hygiene.<br>Int: If Item 27 is marked other than "natur<br>Iny or other traumatic event, the Medical. |                  | Gladys B<br>20a. Method of Disp   |   | fe)   | 20b. Plac                     | ce of Dispo          | sition (Name of                           |   | Ct. Smit                        | hsbu        | rg,Md.                       | 21783   |
| ages<br>ent of<br>nt: If it   |                  | 1 ☐ Burial 2  |   | Removal from State                              | cerr                          | netery, cre          | matory or other plac<br>rg Cremat         | orn Feb                                     | 0.1,                            |             | •                            |   |
| - 555 E   |                  | 21. Signature of Fu   |   | <u> </u>  |                               |                      | 2. Name and Addre                         | 21 20                                       | 708                             |             | thsburg<br>Bradbur           | -   |
| permi<br>Depar<br>Impor<br>any ir   |                  | 12 Te   | er les  | Davis,  | MO14                          | 1/4/3.               | .L. Davis                                 | Funeral                                     |                                 |             |                              | y Ave.<br>1. 21783                              |
|   |                  | 29a. Part1. Enter t<br>shock, or hea  | he disease, or con<br>irt f <i>a</i> ilure. List only | plications that caused<br>one cause on each lir | the death.                    | Do not en            | ter the mode of dyir                      | ng, such as cardiac                         | or respiratory a                | rrest,      |                              | Approximate<br>Interval Between                 |
| Physician   |                  | Immediate Cause (<br>disease or conditio<br>resulting in death)                         | (Final<br>n   | a.CERFB   | 20                            | V 1)3                | WIAIZ                                     | DISENI                                      | rF                              |             |                              | Onset and Death                                 |
| /Medical<br>Examiner  |                  | resulting in death)   |   | Due to (or as                                   | a consequer                   | nce of):             | 2(E) )                                    | CEACE                                       |                                 |             |                              | 1.5120  |
| n   | er               | Sequentially list co<br>if any, leading to im<br>cause. Enter Unde<br>Cause (Disease or | nditions,<br>nmediate                                 | b. Due to (or as                                | a conse der                   | nce of):             | ITRYP                                     | リンド・リンエ                                     |                                 |             |                              | YEAR  |
| executed<br>n and<br>ial-transit  | Examine          | that initiated events   |   | SISCHE  | 1111                          | C (1                 | 92010n                                    | MYDAT                                       | HU                              |             | 1                            | VEAR  |
| w w =   | EX               | resulting in death) l   | _ast  | Due to (or as                                   | a consequer                   | nce of):             |   | 17  | 7                               |             |                              | 7   |
| leath certificate be attending physici  | Physician/Medica |   |   | d   |                               |                      |   |   | ^                               |             |                              |   |
| law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the  | /Me              | IF FEMALE:  | t prognest  | 23c. If yes, outcome                            | pf pregnanc                   | cy                   |   |   |                                 | 25          | 3d. Date of deli             | iven  |
| death<br>e atter<br>d for u   | iciar            | 23b. Was deceden<br>in the past 12<br>1 ☐ Yes 2 [                                       | months?   | 1 ☐ Live birth<br>4 ☐ Pregnant at               |                               |                      | □Ectopic pregnancy<br>□ Other (specify) _ | у   |                                 | 2           | Month                        | Day Year  |
| at the<br>by the<br>tacher  | hys              | 9 □ Unknown   |   | 9□Unknown                                       |                               |                      |   |   |                                 |             |                              |   |
| res that the death cer<br>igned by the attendir<br>be detached for use  | by P             | Part II. Other signif   | ficant conditions                                     | contributing to death bu                        | ut not resultii               | ng in the u          | nderlying cause giv                       | en in Part I.                               |                                 |             | , we                         | the cause of death?                             |
| w requii  | eted             |   |   |   |                               |                      |   |   | 10                              | res 2112    | No 3⊟Pr                      | obably 4 Unknown                                |
| 0 5 0   | Completed        |   |   |   |                               |                      |   |   | 24a. Was                        |             | 24b. Were au prior to death? | topsy findings available completion of cause of |
|   |                  | 25. Was case refer  | red to medical  | <u> </u>  |                               |                      |   | 00 51 (5)                                   | 1□ Yes                          | 2 HNo       | 1 ☐ Yes                      | 2 □ No  |
| Physician:<br>rthis certific<br>ral director,   | To Be            | examiner?   |   | Hospital: Inpatie                               | ent 2∏EF                      | R/Outpatier          | nt 3 DOA Oth                              | 26. Place of Deather:                       | ome 5 ☐ Resid                   |             | Other (Spe                   | cifu)   |
| ng Ph<br>fter th  |                  | 27. Manner of Deat  | h<br>5 Pending  | 28a. Date of Inju                               | ry 25                         | 8b. Time o<br>Injury |   |   | 28d. Describe                   |             |                              | ony   |
| Attending r death. ector: After oy the funer  | catic            | 2 ☐ Accident<br>3 ☐ Suicide   | investigatio  | n   |                               |                      | M 1 🗆                                     | Yes 2 □ No                                  |                                 |             |                              |   |
| or At<br>after d<br>Direct<br>in by   | Certification:   | 4 ☐ Homicide  | determined  |   | ury - At home<br>c. (Specify) | e, farm, sti         | reet, factory, office                     |   | 28f. Location (3<br>City or Tox |             | Number or Ru                 | ıral Route Number,                              |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,               | al Ce            | 29a. Certifier  | 1 ☐ Certifying P                                      | hysician: To the best of                        | of my knowle                  | edge, deat           | h occurred at the ti                      | me, date and place                          | , and due to the                | cause(s)    | and manner as                | stated.   |
| the Ho<br>hin 24 h<br>the Fu<br>npletely  | edical           | (Check only one)  | 2 Medical Exa   | miner: On the basis of<br>and manner sta        | f examination                 | n and/or in          | vestigation, in my o                      | opinion, death occu                         | rred at the time,               | date and    | place, and due               | to the cause(s)                                 |
| Vithi<br>To t   | Me               | 29b. Signature and  | title of certifier                                    | 1 /1/1/1  |                               | _                    | 29c. Licens                               | se number                                   |                                 | 29d. Date   | signed (Mont                 | h, Day, Year)                                   |
| (n. n.  |                  |   | 1/W19   | MILUU   | 0516                          | 1M                   | 1) 1)00                                   | 122043                                      | 5                               | 4           | 1/05                         |   |
| M'XX  |                  | 30. Name and addr   | ess of person who                                     | completed cause of de                           | eath (Item 2:                 | 3a) (Type,           | Print) IAC =                              | 2 (TRICAL)                                  | N 111                           | ) 71        | 747                          |   |
| Sta   | te               | 31. Date filed (Mon   | th, Day, Year)  | 32. Registra                                    | ar's Signatur                 | re                   | 171) 4 (                                  | r-10 VV                                     | - 111                           |             |                              |   |
| Registr   | ar               | P   | LB U 4 2  | 008   | Start S                       | 1                    | m   |   |                                 |             |                              |   |

|      |                                |  |                | 1 - State<br>Registrar  | — — — — — — — — — — — — — — — — — — —  | -                            | tificate of                        |  | R  | eg. No.2         | 0.8         | 04317  |
|------|--------------------------------|--|----------------|---|--|------------------------------|------------------------------------|--|--|------------------|-------------|--|
|      | п                              | Physici  | ian            | Decedent's Name (First, Middle, Last  |  |                              |                                    |  | <ol><li>Date of Dear<br/>Month</li></ol>     | Day              | Year        | 3. Time of Death                                   |
|      |                                | /Medi  |                | Joseph Frederi  |  |                              |                                    |  | Februar                                      | y 3, 20          |             | 1:45 P M   |
|      |                                | Examir   | ner            | 4a. Facility Name (If not institution, give   | · ·  |                              |                                    | or Location of Death                   |  | 4c. County       |             |  |
| _    |                                |  | 3/2            | St. Mary's Hospit  5. Social Security Number 6. S   |  | I 4 f - 1 - 1 - 1            | Le<br>If Under 1 Year              | eonardtown                             |  |                  |             | ary's  |
|      | Ľ                              | Funeral<br>Director  |                |   | 7. Age (In yrs. 89   | Yrs.                         | Months Days                        | Hours Min.                             | 8. Date of Birth<br>(Month, Day<br>Septembe: | , Year)          |             | place (State or Foreign<br>htry)<br>ryland         |
|      |                                | /land  |                | 10a. State 10b. County  | 10c. City  | , Town or Lo                 | cation                             |  |  |                  | 1           | Od. Inside City Limits                             |
|      |                                | Mary<br>ied s  | to             | Maryland St.  | Mary's   |                              | Lovev                              | ille                                   |  |                  |             | 1 ☐ Yes 2X No                                      |
|      |                                | r 28a  | Director       | 10e. Street and Number  |  |                              | 10f. Zip Code                      |  | 1  | Og. Citizen of V | /hat Coun   | ntry?  |
|      |                                | th wit   | al D           | 28360 Point Look  | ut Road  |                              |                                    | 20656                                  |  |                  | USA         |  |
|      |                                | ems<br>er mu   | Funeral        | 11. Marital Status  | 12. Was Decedent Ever in U. Armed Forces?  | S. 13.                       | Was Decedent of F                  | Hispanic Origin? (Spe                  | city Yes or No-                              |                  | e - Americ  |  |
|      | Baltimore, Maryland 21215-0036 | should be filed within 72 hours after death with the Maryland nd Mental Hyglene.  r marked other than "natural", or items 23a or 28a-f show marked other than "hatural", or items 25a or 28a-f show umatic event, the Medical Examiner must be notified at | b              | 1 ☐ Never Married 2X Married<br>3 ☐ Widowed 4 ☐ Divorced  | 1XIYes 2 ☐ No<br>If Yes, Give<br>Year or Dates:  |                              | 1 ☐ Yes 21☑ No                     |  | noan, etc.)                                  |                  | k, White, o |  |
|      | 5-0                            | 72 h<br>'natu<br>dical   | etec           | 15. Decedent's Ed<br>(Specify only highest gra  | ucation<br>de completed)   | 16a. Deced                   | lent's Usual Occup                 | pation<br>during most of working<br>d) | na I   | 16b. Kind of Bu  | siness/Inc  | dustry   |
|      | 121                            | d within 72 ho<br>giene.<br>r than "natu<br>he Medical   | Completed      | Elementary/Secondary (0-12)   | College (1-4or 5+)   |                              |                                    |  |  | U.S. Go          | vernr       | nent   |
|      | 22                             | illed v<br>Hygie<br>ther t   | ပိ             | 10<br>17. Father's Name ( <i>First, Middle, Last</i> )  |  | ripe                         | e Install                          | 18. Mother's Name                      | /First Middle I                              | Maidae Cura      | -1          |  |
|      | and                            | d be fantal l  | Be C           | William Alfred Bo   | wlee   |                              |                                    |  | olivia                                       |                  | 9)          |  |
|      | 7                              | hould<br>mark<br>matic   | 은              | 19a. Informant's Name/Relationship  |  | 19h Mailir                   | ng Addrass (Street                 | and Number or Rura                     |  |                  | Ctata Zia   | Code   |
|      | Ma                             | nd 2 s<br>Ilth ar<br>27 is<br>r trau   |                | Frances Nina Bowl   |  | 1                            | Box 65                             | Lovevil:                               |  |                  | 31a16, 21p  | Code)  |
|      | ē,                             | les 1 and 2 should be filed wo of Health and Mental Hygier of Hem 27 is marked other the other traumatic event, the  |                | 20a. Method of Disposition  | 20b. P   | lace of Dispo                | sition (Name of                    | D                                      |  | 20c. Location -  | City or To  | wn, State  |
|      | E O                            | Pages<br>ent of I<br>nt: If Ite<br>ry or o'  |                | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify  | nemoval from State   |                              | natory or other pla<br>norial Gard | Februa                                 |  | Leonardto        | wn Ma       | rvland   |
|      | alti                           | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.   |                | 21. Signature of Funeral Service Licen  |  |                              | . Name and Addre                   |  | .6   | 2conar a co      | vii, 11d    | Tyrand   |
|      | m                              | a m Dec  |                | Thickael K-   | Lardener   |                              | Mattingles<br>P.O. Box 2           | y <b>-</b> Gardiner Fu<br>70 Leonard   | neral Hor<br>town, MD                        | me P.A.<br>20650 |             |  |
|      | ľ.                             |  |                | 23a. Parth. Enter the disease, or companies shock, or heart failure. List only                              | olications that caused the death   | n. Do not ent                | er the mode of dyi                 | ng, such as cardiac o                  | r respiratory arr                            | est,             |             | Approximate<br>Interval Between<br>Onset and Death |
| 5    |                                | Physician  |                | Immediate Cause (Final disease or condition   | a LESPIRATO  | PY 7                         | MLVRE                              |  |  |                  |             | Onset and Death                                    |
| 0    |                                | /Medical<br>Examiner   |                | resulting in death)   | Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)   | uence of):                   |                                    | c nau                                  |  | × 5.7 = 0        |             | St   |
| 3    |                                |  | -              | Sequentially list conditions,   | Due to (or so a conseque   | O 1455                       | IRUCITO                            | C PULA                                 | C3747 15C.                                   | 1 MACA           | <b>DE</b>   | Y Enes   |
| Bowl |                                | ted<br>nsit  | nju            | Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Coler to (or as a consequ  | P-7                          | AND TERV                           | MIETS                                  | _  |                  |             | YEARS  |
| •    | ,                              | icate be executed<br>physician and<br>s the burial-transit   | Examiner       | that initiated events<br>resulting in death) Last   | c Due to (or as a consequ  | uence of):                   | 12/212/                            |  |  |                  |             |  |
| *    | 09289                          | e be sicial  |                |   | d  |                              |                                    |  |  |                  |             |  |
| 7    | 68                             | rtificat<br>ng phy<br>as th  | Wedical        |   | u  |                              |                                    |  |  |                  |             |  |
| e)   | Вох                            | leath cer<br>attendin<br>for use   |                | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome pf pregna<br>1□Live birth 2□Feta  |                              | Tatania nuo anno                   |  |  | 23d. Dat         | e of delive | ∍ry  |
| ā    |                                | ed for   | Sicie          | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4☐Pregnant at time of de   |                              | Ectopic pregnanc Other (specify)   |  |  | Moi              | nth         | Day Year   |
| 9    | P.0                            | at the<br>i by th<br>stach   | Physician/I    | 9 🗆 Unknown   | · · · · · · · · · · · · · · · · · · ·  |                              |                                    |  |  |                  |             |  |
| 11   | S,                             | w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burat-transit   | þ              | Part II. Other significant conditions of  | _  | _                            | nderlying cause giv                | ven in Part I.                         |  |                  |             | he cause of death?                                 |
| 4    | cords,                         | requi  | Completed      | 17:710=1=   | The Court of the C |                              | -                                  |  | 1 L Y  | es 2 No          | 3   Prob    | pably 4/2 Onknown                                  |
| _    | 3ec                            | e la<br>has<br>e 2   | nple           |   |  |                              |                                    |  | 24a. Was a autops                            | sy l p           | rior to cor | psy findings available<br>mpletion of cause of     |
| d    | a                              | ate<br>pa(   | 8              |   |  |                              |                                    |  | perform                                      |                  | leath?      | 2 No   |
| Sep  | or Vital                       | slclan:<br>certific  | Be             | 25. Was case referred to medical examiner?  | Hospital:  |                              | · all pos Oth                      | 26. Place of Death                     | `  |                  |             |  |
| 0    |                                | Phys<br>r this<br>ral di   | ٠ <u>.</u>     | 1 ☐ Yes 2 ☑ No  27. Manaer of Death   | Hospital: Inpatient 2   28a. Date of Injury  | ER/Outpatien<br>28b. Time of | 1 3 L DOM                          | 4 L Nursing Hor                        |  | ence 6 Othe      |             | v)   |
| 10   | O                              | Attending Physician: r death. ector; After this certifica y the funeral director, I  | tion           | 1 Natural 5 Pending 2 Accident investigation  | (Month, Day Year)  | Injury                       | Wo                                 | rk?<br> Yes 2 □ No                     | od. Describe no                              | ow injury occurr | 3 <b>u</b>  |  |
| 11   | Division                       | Attend<br>r death<br>ector:  | fica           | 3 Suicide 6 Could not be  | 28e. Place of injury - At no   | me, farm, str                |                                    |  | 8f. Location (St                             | treet and Numbe  | er or Rura  | al Route Number,                                   |
|      | ō                              | To the Hospital or Atten within 24 hours after death To the Funeral Director: completely filled in by the  | Certification: | 4 ☐ Homicide determined   | building, etc. (Specify  | "                            |                                    |  | City or Tòwi                                 | n, State)        |             |  |
|      |                                | hours<br>hours<br>uners  |                | 29a. Certifier 1 Certifying Ph  | vsiclan: To the best of my kno-<br>liner: On the basis of examina  | wledge, death                | occurred at the ti                 | ime, date and place, a                 | and due to the c                             | ause(s) and ma   | nner as si  | tated.   |
|      |                                | the H<br>nin 24<br>the Fi  | Medical        | une)  | and manner stated.   | aon and/or m                 |                                    |  |  |                  |             |  |
|      |                                | with To  | 2              | 29b. Signature and title of certifier   |  | MIN                          | 29c. Licens                        |  | 2  | 9d. Date signed  |             | - •  |
|      |                                |  |                |   | <u> </u>   | 1                            |                                    | 12096                                  |  | 2-4-             | . 05        |  |
|      | (                              | 20   |                | 30. Name and address of person who of PATBINDER   | completed cause of death (Item   | 23a) (Type,                  | Print)                             | Es, HULLY                              | West to                                      | nin              | 2           | 0626   |
|      | ng.                            | Sta  | et o           | 31. Date filed (Month, Day, Year)   | 32 egistrar's Signa  | true                         |                                    | 11/100                                 | 0007   | (1)              |             |  |
|      |                                | 318  | ite.           | FED 0 F 2   |  | to A.                        | -03                                |  |  |                  |             |  |

|  |                        | 1 - State Registrer  1. Decedent's Name (First, Middle, Last  | State of Maryland   |   | e of Death   | 2. Date of Deat   | g. No.   | 3. Time of Death                           |
|--|------------------------|---|---|---|--|---|--|--|
| Physici<br>/Medic  | cal                    | James  4a. Facility Name (If not institution, give  | e street and number)  | BOV<br>4h City  | Od<br>Town, or Location of Deat  | Month 1/29  | Day Year<br>9/08<br>4c. County of Death                              | 9:45 a                                     |
| Examir   | ier                    | Washington Adver  |   |   | oma Park   | ,   | Montgome   |  |
| Funeral<br>Director  |                        | 5. Social Security Number 6. S  |   | birthday) If Under Months   |  |   | Q Birth  | nplace (State or Fore<br>untry)<br>rer, CO |
| ilied at   | tor                    | 10a. State 10b. County  MD Prince (   |   | own or Location   |  |   |  | 10d. Inside City Lim<br>1 ☐ Yes 2 🖾 f      |
| or 28  | Director               | 10e. Street and Number  |   | 10f. Zip  | Code   | 10  | g. Citizen of What Co  | untry?                                     |
| 23a  | ral                    | 5700 Queens Chape   |   |   | 20782  |   | U.S.A.   | )  |
| natural', or Items 23a or 28a-f ehow<br>zigal Examinar must be nutified at | by Funeral             | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  | 12. Was Decedent Ever in U.S. Armed Forces? 1 選Yes 2 □ No 1941 If Yes, Give Year or Dates: 1943   | -   | dent of Hispanic Origin? (S<br>offy Cuban, Mexican, Puer<br>2 <sup>12</sup> No <i>Specify:</i> | oecify Yes or No-<br>to Rican, etc.)  | 14. Race - Ame<br>Black, White<br>Specify: W                         |  |
| - 9  | Completed              | 15. Decedent's Ec<br>(Specify only highest gra<br>Elementary/Secondary (0-12)   | ducation (de completed)  College (1-4or 5+)   | 6a. Decedent's Usua<br>(Give kind of wo.<br>life. DO NOT us                                 | al Occupation<br>rk done during most of wo<br>se retired)                                      | rking I   | 6b. Kind of Business/<br>Beltsville                                  | Agricultu                                  |
| giane.   | E O                    | cionomaly (o 12)  | 5+  | Animal Ps   | ychologist   | I   | Research Ce  | enter                                      |
| nd Mental Hygi<br>I marked other<br>umatic event, II                       | To Be (                | 17. Father's Name (First, Middle, Last)  James Bond   |   |   | Flor   | me (First, Middle, M<br>cence Maxv  | vell   |  |
| and<br>s m   |                        | 19a. Informant's Name/Relationship (  |   | 19b. Mailing Address  | (Street and Number or Re   | ural Route Number,  | City or Town, State, Z   | Tip Code) Apt. 1                           |
| f Health<br>Item 27 I  |                        | Shirley A. Bond,  |   |   | ns Charel Ro   |   |  |  |
| 4 E C  |                        | 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐   | TUBILIONAL HOLLI STATA  | e of Disposition (Name<br>etery, crematory or o   | 1  |   | Oc. Location - City or   |  |
| ant:   |                        | 4 □ Donation 5 □ Other (Specifi   |   | opolitan C  |  | /31/2008  | Alexandria   |  |
| Departr<br>Import<br>any inju  |                        | 21. Signature of Funeral Service Licer  | 01 1 .1 .   | Period I  | d Address of Facility  Funeral Ho  | 75. 4   |  | timore Av<br>.11e, MD 2                    |
| ysician and  | cal Examiner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    | b. Due to (or as a consequent of the consequent | KD  | men p  | res;  | E  |  |
| ied by the attending phy<br>detached for use as the                        | Physician/Medi         | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of deat  | ath 3□Ectopic pr  |  |   | 23d. Date of deli<br>Month   | ivery<br>Day Year                          |
| ad be  | þ                      | Part II. Other significant conditions of  | ontributing to death but not resulting  | ng in the underlying c  | ause given in Part I.  | -   | acco use contribute to<br>s 2 □ No 3 □ Pro                           | the cause of death                         |
| - O  | ete                    |   |   |   |  | 24a. Was ar<br>autops<br>perform<br>1 Yes 2   | prior to death?  | topsy findings availation of cause         |
|  | Completed              |   |   |   |  | ath (Chack anh) on  | 9)   |  |
|  | BeC                    | 25. Was case referred to medical examiner?  | Hospital:   |   | 26. Place of De  | atti (Crieck Orlly Orle   |  |  |
| this certifica<br>al director, p   | To Be C                | examiner? 1 Yes 2 No  |   | /Outpatient 3 DC  | Other: 4 Nursing H   | lome 5 Reside   | nce 6 Other (Spec  | cify)                                      |
| this certificate has been signal director, page 2 should be                | To Be C                | examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not bi   | 28a. Date of Injury (Month, Day Year)   | b. Time of 2<br>Injury M  | OA Other: 4 Nursing H<br>8c. Injury at<br>Work?<br>1 Yes 2 No                                  | lome 5 Reside<br>28d. Describe ho   | w injury occurred  |  |
| this certifica<br>al director, p   | Certification; To Be C | examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined   | 28a. Date of Injury (Month, Day Year)  28b. Place of Injury - At home building, etc. (Specify)  | bb. Time of Injury M  | Other: 4 Nursing Files. Injury at Work? 1 Yes 2 No   | 10me 5 Reside<br>28d. Describe ho<br>28f. Location (Str.<br>City or Town                      | w injury occurred<br>eet and Number or Ru<br>. State)                | iral Route Number,                         |
| this certifica<br>al director, p   | Certification; To Be C | examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 2 Accident investigation 3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Ph            | 28a. Date of Injury (Month, Day Year)  28a. Place of Injury - At home   | bb. Time of Injury M  a, farm, street, factory  | Other: 4 Nursing H   | e, and due to the ca  | w injury occurred  eet and Number or Ru State)  use(s) and manner as | ral Route Number,                          |
| after death.  Director: After this certifics in by the funeral director.   | To Be C                | examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier (Check only 2 Medical Exam | 28a. Date of Injury (Month, Day Year)  28a. Place of Injury - At home building, etc. (Specify)  28b. Place of Injury - On the best of my knowle injurer: On the basis of examination  | bb. Time of Injury M  a, farm, street, factory  idge, death occurred a and/or investigation | Other: 4 Nursing H   | 28d. Describe ho  28f. Location (Str. City or Town  e, and due to the caurred at the time, da | w injury occurred  eet and Number or Ru State)  use(s) and manner as | stated. to the cause(s)                    |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

|  |                  | For<br>State<br>Registrar   |                              |   |                                     |                       |                            |                         |                          | Death   |                            |                                      | Reg. No               | -2 H                       | 08                                   | 0431  |
|--|------------------|---|------------------------------|---|-------------------------------------|-----------------------|----------------------------|-------------------------|--------------------------|---|----------------------------|--------------------------------------|-----------------------|----------------------------|--------------------------------------|---|
| . Physic   |                  | 1. Decedent's Name (First, I<br>Lecnard Litt  | fiddle, Las<br><b>leto</b> n | Bransf  | ford                                |                       |                            |                         |                          |   |                            | Date of De<br>Month<br>anuary        |                       | 2008                       | Year                                 | 3. Time of Death 7:14 P                       |
| Exam   |                  | 4a. Facility Name (If not insti<br>5303 Tinkers Cr  |                              |   | nber)                               |                       |                            |                         | , Town, o                | r Location of D                               | Death                      |                                      | 40                    | c. County of               | f Death                              |   |
| Funera<br>Directo  |                  | 5. Social Security Number <b>577–86–7882</b>  |                              | ex<br>□M 2□F  | 7. Age (In<br>53                    |                       | birthday)<br>Yrs.          | If Undo<br>Months       | er 1 Year<br>Days        | If Under 24<br>Hours                          | Hrs. 8.<br>Min. 0          | Date of Bir<br>(Month, Da<br>8/25/19 | th<br>ay, Year<br>954 | S                          | Caui                                 | place (State or Foreig<br>ntry)<br>America    |
| Maryland<br>a-f show   | tor              | Usual Residence of Deceder  10a. State 10b. Co  |                              |   | 100                                 |                       | own or Lo<br>Linta         |                         |                          |   |                            |                                      |                       |                            |                                      | 0d. Inside City Limits                        |
| h with the<br>23a or 28a<br>st be not  | Funeral Director | 10e. Street and Number<br>5303 Tinkers Cr   | eek Pl                       | ace   |                                     |                       |                            | 10f. Z                  | ip Code<br><b>2073</b> 5 |   |                            |                                      | 10g. Ci               | itizen of Wh               |                                      | ntry?   |
| IOTC, INICITIES IN A LAID-UUSO  ges 1 and 2 should be filed within 72 hours after death with the Maryland  nt of Health and Mental Hygiene. If Item 271s marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at   | <u>و</u>         | 3 □ Widowed 4 □ Divo  |                              | 12. Was Dece<br>Armed For<br>1 XYes<br>If Yes, Give<br>Year or Da | 2 □ No<br>e <b>¬</b> c              | in U.S.               |                            |                         | edent of Hecify Cuba     | lispanic Origin<br>an, Mexican, F<br>Specify: | n? (Specify<br>Puerto Rice | / Yes or No<br>an, etc.)             | )-                    |                            | Americ<br>White,                     |   |
| Z I Z I 3-UU30 cd within 72 hours af giene. er than "natural", or , the Medical Exami  | Completed        | 15. Dec<br>(Specify only I  | Ť                            | ucation<br>de completed)<br>College (1-                           | -4or 5+)                            | НĪ.                   | (Give<br>life. I           | kind of w<br>DO NOT     |                          | during most of<br>d)                          | f working                  |                                      | 16b. F                | Kind of Busi               | iness/In                             | dustry  |
| lal ylallu LIL<br>2 should be filed within<br>and Mental Hygiene.<br>Is marked other than<br>aumatic event, the M  | S                |   |                              | 66  | · · · · · ·                         |                       | Deputy                     | y Chie                  | ef Dir                   |   |                            |                                      | 1                     | eral G                     |                                      | ment  |
| the fill he other of the other of the other of the other of the other ot | Be               | 17. Father's Name (First, Mi  |                              |   |                                     |                       |                            |                         |                          | 18. Mother's Floret                           |                            |                                      | , Maidei              | n Surname,                 | )                                    |   |
| nd 2 should be file that and Mental Hy 27 is marked oth  | 2                | 19a. Informant's Name/Rela  |                              | Type. Print)  |                                     | 1                     | I9b. Mailir                | ng Addres               | ss (Street               | and Number of                                 |                            |                                      | er, City              | or Town, S                 | tate, Zij                            | Code)   |
| C, IVICA<br>1 and 2 s<br>Health ar<br>Health ar<br>em 27 Is  |                  | Norma Trotman -   | Wife                         |   |                                     |                       | 5303 :                     | Tinker                  | rs Cre                   | ek Place                                      | ; Clir                     | ntan, N                              | /aryl                 | and 2                      | 0735                                 | ,   |
| permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other trense.   |                  | 20a. Method of Disposition 1 Burial 2 □ Crema 4 □ Donation 5 □ Oth  |                              |   | siale                               |                       | e of Dispo<br>etery, cres  |                         | ame of<br>other place    |   | Date 4/2008                |                                      |                       | ocation - C                |                                      |   |
| permit. Pages of permit. Pages of pepartment of limportant: If ite any injury or of once.  |                  | 21. Signature of Funeral Se   |                              |   | na.                                 | n.                    | 22                         | 2. Name a               | and Addre                | ss of Facility<br>cad; Ten                    | reemar                     | n Funer                              | al S                  | ervice                     | S                                    | /Idi U  |
|  |                  | 23a. Part1 Enter the disease shock, or heart failure.   | e, or comp                   | olications that ca  | aused the                           | death. [              |                            |                         |                          |   | _                          |                                      |                       | aru zu                     | 740                                  | Approximate<br>Interval Between               |
| Physician<br>/Medical  |                  | Immediate Cause (Final disease or condition resulting in death)   | List only o                  | a   | Brain                               | Cano                  | er                         |                         |                          |   |                            |                                      |                       |                            |                                      | Onset and Death                               |
| Examine  |                  | Sequentially list conditions,   |                              | b   | or as a col                         |                       |                            |                         |                          |   |                            |                                      |                       |                            |                                      |   |
| uted<br>d<br>ansit   | i ii             | cause. Enter Underlying Cause. Undeaded or hybry that initiated events  c.  |                              |   |                                     |                       |                            |                         |                          |   |                            |                                      |                       |                            |                                      |   |
| death certificate be executed teath certificate be executed e attending physician and d for use as the burial-transit  |                  | resulting in death) Last  |                              | Due to (d   | or as a cor                         | nsequen               | ce of):                    |                         |                          |   |                            |                                      |                       |                            |                                      |   |
| tificate<br>ng phy<br>as the   | Medical          |   |                              | u   | - 52 -                              |                       |                            |                         |                          |   |                            |                                      |                       |                            |                                      |   |
| the death cer<br>y the attendin  | Physician/N      | IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | t                            | 23c. If yes, outo<br>1 □ Live bi<br>4 □ Pregna<br>9 □ Unkno       | irth 2 🗆<br>ant at time             | Fetal de              | ath 3[                     | ⊒Ectopic<br>⊒ Other (:  | pregnancy<br>specify)    | У   |                            |                                      |                       | 23d. Date<br>Mont          |                                      | ery<br>Day Year                               |
| hat<br>hat<br>d b  | þ                | artii. Other significant co   | nditions co                  | ontributing to de   | ath but no                          | t resultin            | g in the u                 | nderlying               | cause giv                | en in Part I.                                 | _                          |                                      | tobacco<br>Yes 2      |                            |                                      | he cause of death?<br>pably 4 □Unknow         |
| The law requires t<br>ate has been signe<br>page 2 should be o   | Completed        |   |                              |   |                                     |                       |                            |                         |                          |   |                            | 24a. Was<br>auto<br>perfo<br>1□ Yes  |                       | pri<br>de                  | ere auto<br>ior to co<br>ath?<br>Yes | opsy findings availab<br>mpletion of cause of |
| ysician; The ils certificate hadirector, page  | Be               | 25. Was case referred to me examiner?   | - H                          |   |                                     |                       |                            |                         |                          | 26. Place of                                  | Death (C                   | heck only                            |                       |                            |                                      |   |
| ing Physician;<br>After this certifics<br>uneral director, I   | 2                | 27. Manner of Death   | -                            | 28a. Date o   | npatient<br>of Injury<br>h, Day Yea | 28                    | Outpatier b. Time o Injury | f                       | 28c. Injur<br>Wor        | y at<br>k?                                    | 28d                        |                                      |                       | 6 □Other<br>ury occurred   | . ,                                  | (y)   |
| To the Hospital or Attending Ph<br>Within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral  | rtificati        | 27. Manippor Death  1 Natural 5 Pending investigation  2 Accident  3 Suicide 4 Homicide 6 Could not be determined 5 Pending investigation  288. Date of Injury (Month, Day Year)  288. Place of Injury At home, farm, st building, etc. (Specify) |                              |   |                                     |                       |                            | M 1 ☐ Yes 2 ☐ No        |                          |   |                            |                                      | or Run                | al Route Number,           |                                      |   |
| To the Hospital within 24 hours a To the Funeral I   | Medical Ce       | 29a. Certifier 1 Cer<br>(Check only 2 Me  | tifying Phy<br>lical Exam    | ysician: To the<br>niner: On the ba<br>and mann                   | asis of exa                         | y knowle<br>ımination | dge, deat<br>and/or in     | h occurre<br>vestigatio | d at the tion, in my o   | me, date and popinion, death                  | place, and<br>occurred     | due to the                           | cause(                | s) and man<br>nd place, ar | ner as s<br>nd due t                 | stated.<br>o the cause(s)                     |
| To the within To the comple  | Me               | 29b. Signature and little of co   | fitifier                     | ssa   | ١                                   |                       |                            | 1                       | 9c. Licens               | e number<br>060050                            | · 11'                      |                                      |                       | ate signed<br>ary 29       |                                      | Day, Year)                                    |
| 2 (5)  |                  | 30. Name and address of pe  |                              |   |                                     |                       |                            |                         | Dr.<br>774               | . Hussair                                     | n, Mah                     | irukh M                              | ushn                  | raf                        |                                      |   |
|  | tate<br>trar     | 31. Date filed (Month, Day,   |                              |   | egistrar's S                        |                       | _=                         |                         |                          |   |                            |                                      |                       |                            |                                      |   |

| State of Maryland / Department of Health and Mer<br>Certificate of Death | ntal Hygiene | 01.32 |
|--|--------------|-------|
| Certificate of Death   | Reg. No.     | 0402  |

certificate be executed sician and burial-tran Division or Vital Records. P.O. Box 68760 attending physician the as asn ned by the atter detached for u signed has this

2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 3:10 p Barksdale Jan. 2008 Katherine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Ye July 15, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) 1926 Halifax Cy, Va Months 1 □ M 2 130 81 Director 577-58-9985 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at ty∑Yes 2 No Prince Georges Director Md. District Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2711 Kirtland Avenue 20747 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2K No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 ☐ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Self-Employed permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygien
Important: If item 27 Is marked other thin 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie Fred Terry Ida L. Barbour ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) District Heights, Md. 20747 2711 Kirtland Ave., Dora D. Barksdale (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery Feb.1,2008 Clinton, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
W. H. Bacon Funeral Home, Inc.
3447 14th Street, N.W. Washington, 21. Signature of Funeral Service Licensee C. Pacon, CC361 DC 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia Maknong Physician /Medical Due to (or as a consequence of): Examiner Una tract 1 itata Sequentially list conditions, if any, leading to immediate cause. Erner ornoenying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Sacral dea bita Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 图 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No autopsy performed? 1 Yes 2 No Attending Physician; completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death, To the Funeral Director; After it (Month, Day Year) 1 DNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier it p 1.28.08 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 980, Georgia Ave suit 3-41. S. lum FARAMIFAR M.p 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

Division or Vital Records. P.O.

13H-5

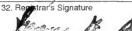
DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) FEB 0 5 2008

29b. Signature and title of certifier

FRANCISCO



respetales

) aniels

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

251

0061

E,

29d. Date signed (Month, Day, Year)

DARAMOR

5 )

|   | ,               | 1 - For State of Maryland / Department of Health and Certificate of Death  | d Mental Hy                                  | giene<br>Reg. No. 2             | 008 0432  |
|---|-----------------|--|--|---------------------------------|---|
| Physicia  | ın              | 1. Decedent's Name (First, Middle, Last)   | 2. Date of De<br>Month                       | eath<br>Day                     | 3. Time of Death<br>Year                                  |
| /Medic  |                 | Mildred A. Conner  |  | ary 29,                         | 2008 11:15p M   |
| Examine   | er              | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De  | eath   | 4c. Cour                        | nty of Death  |
|   |                 | Montgomery Hospice-Casey House Rockville  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 F  | Hrs. 8. Date of Bi                           | th.                             | Montgomery  9. Birthplace (State or Foreign               |
| Funeral Director  |                 | 213-42-9823  | May 29                                       | av. Year)                       | Country) Virginia   |
|   |                 | Usual Residence of Decedent  | 1107 = 0                                     | ,                               |   |
| rylan<br>how<br>Lat   | _               | 10a. State 10b. County 10c. City, Town or Location   |  |                                 | 10d. Inside City Limits                                   |
| ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show item 27 Is marked other than "edical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at | cto             | Maryland Montgomery Silver Spring  |  |                                 | 1 □Yes 2 🖎 XNo  |
| or 2  | Dir.            | 10e. Street and Number 10f. Zip Code   |  | _                               | f What Country?   |
| am w  | Funeral Directo | 14907 Claude Lane 20905  |  | US                              |   |
| item;   | nue             | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu   | ? (Specify Yes or No<br>uerto Rican, etc.)   |                                 | ace - American Indian,<br>lack, White, etc.               |
| rs are  | by F            | 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No Specify: 3 □ Wildowed 4 □ Divorced Year or Dates:   |  | Spec                            | <sub>cify:</sub> White                                    |
| atura   |                 | 15. Decedent's Education 16a, Decedent's Usual Occupation  |  | 16b. Kind of                    | Business/Industry   |
| Medical   | Completed       | (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of life. DO NOT use retired)  | working                                      |                                 | ,   |
| giene<br>giene<br>sr tha  | E               | 12 Homemaker   |  | Own                             | Home  |
| othe<br>vent,   | Be              | 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)   | Name (First, Middle                          | , Maiden Surn                   | ame)  |
| Ment;   | 2               | James O. Edmonds   | Rosa A.                                      | Worch                           | a m   |
| and I sma   | 4               | 19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or   |  |                                 |   |
| n 27 ler tra  |                 | Bette K. Andrakakos/Granddaughter 4560 Kingscup Cour   | t, Ellico                                    | tt City                         | , MD 21042  |
| int: If iten  |                 | 20a. Method of Disposition  X□ Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)   | Date<br>Feb. 2,                              | 20c. Location                   | - City or Town, State                                     |
| Department of Important: If it any injury or o  |                 | 4□Donation 5□Other (Specify)  Fort Lincoln Cemetery  | 2008   | Brent                           | wood, Maryland  |
| Depart<br>Import<br>any inj<br>once.  |                 | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collin   | ns Funera                                    |                                 |   |
| ysicia<br>he bur  | ical Examiner   | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  Due to (or as a consequence of):  |                                 |   |
| within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the complete of the funeral director.         | Physician/Med   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify) □  |  |                                 | Date of delivery<br>Month Day Year                        |
| n signed  | þ               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                                 | ontribute to the cause of death?  3 □ Probably 4 ☑ Unknow |
| s bee   | Completed       |  | 24a. Was                                     |                                 | o. Were autopsy findings availab                          |
| age   | E O             |  | — auto<br>perfe<br>1 Yes                     | ormed?                          | prior to completion of cause of death? 1 ☐ Yes 2 ☐ No     |
| rtifica<br>tor, p   | Φ               | 25. Was case referred to medical 26. Place of I  | Death (Check only                            | one)                            | 7 163 2 100   |
| direc   | To B            | examiner? Hospital: Other:   | g Home 5 ☐ Res                               |                                 | Other (Specify) Hos                                       |
| ter th  |                 | 27. Manner of Death  Yaman Natural 5 Pending 28a. Date of Injury 28b. Time of Injury Work?  28c. Injury at Work?   | 28d. Describe                                | how injury occ                  |   |
| or: A   | Certification:  | 2 Accident investigation M 1 Yes 2 No  |  |                                 |   |
| irect   | Ĕ               | 3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Could not be determined building, etc. (Specify)   | 28f. Location (<br>City or To                | Street and Nui<br>wn, State)    | mber or Rural Route Number,                               |
| irs af  |                 |  |  |                                 |   |
| Fune<br>Fune<br>rtely fi  | ca              | 29a. Certifier 71 Certifying Physician: To the best of my knowledge, death occurred at the time, date and please. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death or one)   | lace, and due to the<br>occurred at the time | cause(s) and<br>, date and plac | manner as stated.<br>e, and due to the cause(s)           |
| thin 2<br>o the   | Medical         | one) and manner stated.  29b. Signature and title of certifier / 29c. License number   |  | 29d, Date sign                  | ned (Month, Day, Year)                                    |
| ₹ E 8   |                 |  |  | -                               | ary 30,2008   |
| U,  | -               | Je chiere (Modelle SIS ")  |  | Janua                           |   |
|   |                 | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Génevieve Wroblewski, MD 6001 Muncaster Mill Road  | , Rockvil                                    | le, MD                          | 20855   |
| Stat<br>Registra  | -               | 31. Date filed (Month, Day, Year)  JAN 3 1 2008  32. Fegistrar's Signature   |  |                                 |   |

|                            |  |                | For State  | State of Ma                            | aryland              |                       | rtment of H                              |                                |                                 | 71111                             | 8 04323   |  |
|----------------------------|--|----------------|--|--|----------------------|-----------------------|--|--------------------------------|---------------------------------|-----------------------------------|---|--|
|                            |  |                | State Registrar  1. Decedent's Name (First, Middl)   | - (201)                                |                      | Cer                   | tificate of l                            | <i>Jeatn</i>                   | 2. Date of Dea                  | og. 110.                          | 3, Time of Death                                    |  |
| 427                        | Physicia   | an             | , ,  |  |                      |                       |  |                                | Month                           | Day Ye                            | ar  |  |
|                            | /Medic<br>Examin   | a to           | Benjamin J 4a. Facility Name (If not institution   |  |                      |                       | 4b. City, Town, or                       | Location of Death              | January                         | 4c. County of E                   |   |  |
|                            | LAAIIIII   |                | Holy Cross Ho  | spital                                 |                      |                       |  | Spring                         |                                 | Montgo                            | omery   |  |
| A Congression              | Funeral  |                | 5. Social Security Number  | 6. Sex 7. Ag                           | ge (In yrs. la       | ast birthday)<br>Yrs. | If Under 1 Year<br>Months Days           | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day | , Year)                           | Birthplace (State or Foreign<br>Country)            |  |
| 9                          | Director   |                | 579-20-9737<br>Usual Residence of Decedent   | X W Z D I                              | 84                   | rrs.                  |  |                                | March 1                         | 6, 1923                           | South Carolina                                      |  |
|                            | land<br>ow   |                | 10a. State 10b. County   |  | 10c. City            | , Town or Lo          | cation                                   |                                |                                 | ·                                 | 10d. Inside City Limits                             |  |
|                            | Many<br>a-f sh<br>ffied  | 호              | Maryland Princ   | e George's                             | For                  | rt Was                | hington                                  |                                |                                 |                                   | XXYes 2 □ No  |  |
|                            | or 28:   | Directo        | 10e. Street and Number   |  |                      |                       | 10f. Zip Code                            | -                              |                                 | I0g. Citizen of Wha               |   |  |
|                            | ath w  |                | 13004 Renfrew  |  | Everie II (          | 2 142.1               | 20744                                    | ionania Orlain? (Si            |                                 | United St                         | tates<br>American Indian,                           |  |
|                            | items<br>ner n   | Funeral        | <ol> <li>Marital Status</li> <li>Never Married 2 Mar</li> </ol>  | 12. Was Decedent<br>Armed Forces?      | ?                    | 5.   13. \            | Was Decedent of H<br>f Yes, specify Cuba | an, Mexican, Puert             | o Rican, etc.)                  | Black, V                          | Vhite, etc.   |  |
| 36                         | al", or  | þ              | 3√2 Widowed 4 □ Divorced   | If Van Giva                            |                      |                       | 1⊡Yes 2 <b>र</b> ∏No                     | Specify:                       |                                 | Specify:                          | Black   |  |
| Ö                          | 72 hou<br>natura<br>lical E  | Completed      | 15. Deceder  | nt's Education<br>est grade completed) |                      | (Give                 | dent's Usual Occup                       | during most of wor             | kina I                          | 16b. Kind of Busin                | ess/Industry  |  |
| 2                          | ithin<br>ne.<br>nan "  | mple           | Elementary/Secondary (0-12)  | College (1-4or                         | 5+)                  | `life. l              | DO NOT use retired                       | 1)                             |                                 | 0                                 |   |  |
| 7                          | flied within 72 hours after death with the Maryland<br>Hygiene.<br>other than "natural", or items 23a or 28a-f show<br>ent, the Medical Examiner must be notified at   |                | 12 years 17. Father's Name (First, Middle,   | Last)                                  |                      | Po                    | lice Offi                                |                                | ne (First, Middle,              | Gover: Maiden Surname)            | nment   |  |
| and                        | d be f<br>ental F<br>ced ol  | Be C           | Envelo S. Cha  | _                                      |                      |                       |  |                                | h Wallac                        |                                   |   |  |
| Maryland 21215-0036        | 2 should<br>and Mer<br>is marke<br>aumatic   | 은              | 19a. Informant's Name/Relations  | -                                      |                      | 1                     | ,  | and Number or Ru               | ıral Route Numbe                | r, City or Town, Sta              |   |  |
|                            | and 2<br>ealth a<br>n 27 is<br>ner trai  |                | Timothy J. Char  | olin, Sr S                             | Son                  | 13004                 | Renfrew                                  | Circle H                       | t. Washi                        | ington, M                         |   |  |
| ore                        | of He  |                | 20a. Method of Disposition  1 XBurial 2 Cremation  | 3 □Removal from State                  |                      | ametery cial          | sition (Name of<br>matory or other place | ce)                            | Date 1 200                      | 20c. Location - Cit<br>20c. Laure |   |  |
| <u><u>E</u></u>            | Pages tment of I tant; If its jury or o  |                | 4 Donation 5 ☐ Other (   | Specify)                               | Mar                  |                       | Nat'l Men                                |                                |                                 |                                   |   |  |
| Baltimore,                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |                | 21. Sig \ ture of Funeral Service  | Ligarde 9                              | 15                   |                       |  |                                |                                 | ineral Ho<br>ington, D            |   |  |
| Υ.                         |  |                | 23a. Parti. Enter the disease, of shock, of heart failure. Lis   | r complications that cause             | ed the death         |                       |  |                                |                                 |                                   | Approximate   |  |
|                            | Physician  |                | Immediate Carre (Final   |  |                      | _                     |  |                                |                                 |                                   | Interval Between<br>Onset and Death                 |  |
|                            | /Medical   |                | disease or condition resulting in death)   | a. Septic Due to (or as                |                      |                       |  |                                |                                 |                                   |   |  |
| 5                          | Examiner   |                | Sequentially list conditions   |  |                      |                       | s Ulcer                                  |                                |                                 |                                   |   |  |
|                            | sit sit  | Examiner       | Sequentially list conditions, liany, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to or as                           |                      |                       |  |                                |                                 |                                   |   |  |
|                            | and I-trans  | xam            | that initiated events<br>resulting in death) Last  | c. Chroni Due to (or as                |                      |                       | _sease                                   |                                | -                               |                                   |   |  |
| 760,                       | te be executed<br>ysician and<br>e burial-transit  | calE           |  | d Hypoxi                               | a                    |                       |  |                                |                                 |                                   |   |  |
| 89                         | ifficate<br>g phy:<br>as the   |                |  | u                                      |                      |                       | -  |                                |                                 |                                   |   |  |
| Box                        | w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit  | M/us           | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome                   |                      |                       | ∃Ectopic pregnanc                        | v                              |                                 | 23d. Date of                      | · · · ·   |  |
| о.<br>В                    | e deal<br>he att   | Physician/Med  | in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 4□Pregnant a<br>9□Unknown              | at time of d         | eath 5[               | Other (specify)                          |                                |                                 | Month                             | Day Tour  |  |
| <u>P</u>                   | The law requires that the death certifical tite has been signed by the attending phyage 2 should be detached for use as the  |                | Part II. Other significant condit  | ions contributing to death             | but not resi         | ulting in the u       | nderlying cause giv                      | ren in Part I.                 | 23e. Did to                     | obacco use contribu               | ute to the cause of death?                          |  |
| ds,                        | signe<br>d be c  | d by           |  |  |                      |                       |  |                                | 1 🗆 🗅                           | 1  Yes 2 No 3 Probably 4 ∏Unkno   |   |  |
| COL                        | w requ   | Completed      |  |  |                      |                       |  |                                | 24a. Was                        |                                   | re autopsy findings available                       |  |
| Re                         | The laste has  | dwo            |  |  |                      |                       |  |                                | autop<br>perfo<br>1□ Yes        | rmed? dea                         | or to completion of cause of<br>ath?<br>]Yes 2 □ No |  |
| ita                        |  | BeC            | 25. Was case referred to medic   | al                                     |                      |                       |  | 26. Place of De                | ath Check onl o                 | X                                 |   |  |
| <u>r</u> <                 | hysic<br>his ce<br>I direc   | TO E           | examiner?<br>1 ☐ Yes 2 ☑ No  |  |                      |                       | III JU DON                               |                                | Т                               | dence 6 Other                     |   |  |
| Division or Vital Records, | Attending Physician: The law readh, ector: After this certificate has by the funeral director, page 2  |                | 27. Manner of Death 1 ☑ Natural 5 ☐ Pend   |  |                      | 28b. Time o<br>Injury | Wo                                       | ryat<br>rk?<br>∣Yes 2∐No       | 28d. Describe I                 | now injury occurred               |   |  |
| Sic                        | death<br>ctor  | icati          | 3 Suicide 6 □ Could  | mined   200. Flave of II               | njury - At ho        | ome, farm, st         | reet, factory, office                    |                                |                                 |                                   | or Rural Route Number,                              |  |
| à                          | fer<br>fer<br>Direc  | Certification: | 4 ☐ Homicide deter   | mined building, e                      | etc. ( <i>Specif</i> | <i>(y)</i>            |  |                                | City or Tov                     | vn, State)                        |   |  |
|                            | To the Hospital or Attern<br>within 24 hours after death<br>To the Funeral Director<br>completely filled in by the   |                | 29a. Certifier 1X Certify  | ing Physician: To the bes              | st of my kno         | wiedge, deat          | th occurred at the to                    | me, date and plac              | e, and due to the               | cause(s) and mann                 | ner as stated. d due to the cause(s)                |  |
|                            | To the H<br>within 24<br>To the F<br>complete  | Medical        | one)   | and manner s                           | stated.              |                       |  |                                |                                 |                                   |   |  |
|                            | With To To To To   | Σ              | 29b. Signature and title of certif   | 1 LO .                                 | 7                    |                       | 29c. Licen:                              |                                |                                 | 29d. Date signed (                | cy 27, 2008   |  |
|                            | 18   |                | On Name and add as a fa  | n who completed cause of               | dooth (ltcm          | n 23a) (Tuno          | D625                                     |                                |                                 | Januar                            | 27, 2000  |  |
| K                          | (0)  |                | 30. Name and address of perso  |  |                      |                       |  | Silver                         | Spring.                         | MD 20910                          |   |  |
|                            | St   | ate            | Maria D'Arbe<br>31. Date filed (Month, Day, Yea<br>FEB 0 1 2008  | r) 32. Regis                           | strar's Sign         | ure                   | OTOR ROAD                                | DILVCI                         |                                 |                                   |   |  |
| 2                          | Regist   | rar            | FEB 0 1 2008   | Blow D                                 | A                    | 1842                  |  |                                |                                 |                                   |   |  |

| Physicia<br>/Medica<br>Examina   | al -  | 1. Decedent's Name (First, Middle, Last) Lloyd W. Chishola 4a. Facility Name (If not institution, give s Laurel Regional H   | street and number)   |  | 4b. City, Town, or<br><b>Laure1</b>   | Location of Death  | Jan 23, 20   | 008<br>4c. County o  | 1:50 P of Death Georges  |
|--|---|--|--|--|---|--|--|--|--|
| uneral   | - 1   | 5. Social Security Number 6. Sec   | x 7. Age (   | (In yrs. last birthday)  | If Under 1 Year Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth   |  | 9. Birthplace (State or Forei Cofumbia, S. Ca  |
| irector  | -   | 578-18-2278-B  Wasual Residence of Decedent  | <sup>2</sup> M <sup>2</sup> □ F   <b>87</b>  | Yrs.   |   |  | 107797192  | 20   | Columbia, 5. Ca  |
| how  |   | 10a. State 10b. County   |  | 0c. City, Town or Lo   |   |  |  |  | 10d. Inside City Limi<br>1 ▼Yes 2 □ N  |
| 28a-f s  | Director  | N/A N/A  10e. Street and Number  |  | Washingto  | n, DC   |  | 10g  | Citizen of W   | /hat Country?  |
| 3a or<br>st be n   | 흡   | 4004 S. Dakota Ave   | 20018  |  | United States   |  |  |  |  |
| al', o   | ted by Funeral                                      | 1 Never Married  Married 3 Widowed 4 Divorced  | 12. Was Decedent Every Armed Forces?  Yes 2 PN If Yes, Give Year or Dates: 1   | 1942 -<br>1945   | Was Decedent of H If Yes, specify Cuba  1 Yes No  dent's Usual Occup  | Specify:   | 166  | Specify:   | e - American Indian, k, White, etc. Black siness/Industry  |
| han "n<br>e Medi   | Completed   | (Specify only highest grade  | College (1-4or 5+)   | life.  | pment Tec   | 1)   | _  | edera  | 1 Government   |
| other th   | S   | 17. Father's Name (First, Middle, Last)  |  | Equi   | pmenc rec   |  | ne (First, Middle, Mai   | _  |  |
| rked o   | To Be   | Dub Chisholm   |  |  |   | Genie L  | loyd   |  |  |
| ' is ma<br>rauma   |   | 19a. Informant's Name/Relationship (Ty<br>Mary (Clark) Chish   |  | e 4004   | ng Address <i>(Street a</i><br><b>S. Dakot</b> a  | and Number or Ru<br>1 <b>Ave, NE</b>   | iral Route Number, Ci<br><b>, Washing</b> t  | ity or Town, i   | State, Zip Code)<br>C 20018  |
| Important: If item 2<br>any injury or other<br>once.   |   | 20a. Method of Disposition  1  Burial 2  Cremation 3  F  4  Donation 5  Other (Specify)  21. Signature of Funeral Service Licens   |  | Quantico   | matory or other place National  | Cem: 2/1   | I  | iangle   |  |
|  |   |  |  |  |   | T HOMES  |  |  |  |
|  |   | 23a. Part1. Enter the disease, or complete shock, or heart failure. List only of immediate Cause (Final disease or confliction.  | lications that caused the cause on each line.  | Fo   | restville   | , MD 207   | 47   |  | Approximate<br>Interval Between<br>Onset and Death   |
| sician<br>edical<br>iminer   | cal Examiner  | shock, or heart failure. List only o   | ilications that caused the cause on each line.  a. Sepsis  Due to (or as a or present the control of the contro | ro ne death. Do not en consequence of): ailure   | restville ter the mode of dyir  | , MD 207   | 47   |  | Approximate<br>Interval Between  |
| attending physician and muse as the burial-transit au poison ior use as the burial-transit   | dical   | shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  | ilications that caused the cause on each line.  a. Sepsis  Due to (or as a or present the control of the contro | consequence of): ailure consequence of): ailure consequence of):  Renal Fai consequence of):   | restville ter the mode of dyir  | e, MD 207  | 47   |  | Approximate Interval Between Onset and Death   |
| igned by the attending physician and ignorated for use as the burial-transit and be detached for use as the burial-transit and ignorated for use and ignor | by Physician/Medical                                | shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No   | ilications that caused trine cause on each line.  a. Sepsis  Due to (or as a cause)  C. Chronic  Due to (or as a cause)  | consequence of):  a lure consequence of):  Renal Fai consequence of):  pregnancy Fetal death me of death  35   | Problems  Lure    Ectopic pregnance   Other (specify)   | e, MD 207  | c or respiratory arrest,   | 23d. Dat<br>Mo   | Approximate Interval Between Onset and Death   |
| peen signed by the attending physician and multipolicial policial transit and be detached for use as the burial-transit and burial-transit and be detached for use as the burial-transit and burial-transit an | Physician/Medical                                   | shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  | ilications that caused trine cause on each line.  a. Sepsis  Due to (or as a cause)  C. Chronic  Due to (or as a cause)  | consequence of):  a lure consequence of):  Renal Fai consequence of):  pregnancy Fetal death me of death  35   | Problems  Lure    Ectopic pregnance   Other (specify)   | e, MD 207<br>ng, such as cardiad   | 23e. Did tobac  1  Yes  24a. Was an autopsy performe   | 23d. Dat<br>Mo   | Approximate Interval Between Conset and Death Conset and Death Dea |
| certificate has been signed by the attending physician and the policy page 2 should be detached for use as the burial-transit to be detached for use as the  | Be Completed by Physician/Medical                   | shock, or heart failure. List only o immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | ilications that caused trine cause on each line.  a. Sepsis  Due to (or as a Renal Fab.  Due to (or as a complete of the compl | consequence of): ailure ailcal consequence of): Renal Fai consequence of):  f pregnancy  | restville ter the mode of dyin  Problems  Lure  Ectopic pregnancy Other (specify)  underlying cause giv   | e, MD 207 ng, such as cardiad y ren in Part I.   | 23e. Did tobac  1  | 23d. Dat<br>Mo<br>cco use contr<br>2 No<br>24b. V  | Approximate Interval Between Cnset and Death Cnset and Death Part Part Part Part Part Part Part Part   |
| Hare this certificate has been signed by the attending physician and the properties of the burial-transit and the burial-transit and be burial-transit.  | To Be Completed by Physician/Medical                | shock, or heart failure. List only o immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | ilications that caused trine cause on each line.  a. Sepsis  Due to (or as a Renal Faster)  Due to (or as a General Faster)   | consequence of): ailure ailure consequence of): Renal Fai consequence of):  representation of death of | Problems  Lure    Compare the mode of dying the mode of dying the mode of dying the mode of dying the mode of dying the mode of dying the mode of dying the mode of the mode of dying the mode of the | e, MD 207 ng, such as cardiad  y  ren in Part I.  26. Place of De.   | 23e. Did tobac  1 Yes  24a. Was an autopsy performe 1 Yes  2th (Check only one)  lome 5 Residence 28d. Describe how  | 23d. Date Mo   | Approximate Interval Between Conset and Death Conset and Death Conset and Death Part Con |
| Director: After this certificate has been signed by the attending physician and up positive to be defacted for use as the burial-transit of positive to be defacted for use as the burial-transit.   | To Be Completed by Physician/Medical                | shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | dications that caused trine cause on each line.  a. Sepsis  Due to (or as a Renal Fab.  Due to (or as a G.  C. Chronic  Due to (or as a G.  C. Chronic  Due to (or as a G.  Due to (or as a G.  C. Chronic  Due to (or as a G.  C. Chronic  Due to (or as a G.  Chronic  Due to (or a | consequence of):  a i Lure  a i Lure  consequence of):  Renal Fai  consequence of):  f pregnancy  Fetal death me of death  not resulting in the understand the second of t | Problems  Problems  Lure  Ectopic pregnancy Other (specify)  underlying cause give  and 3 DOA Other  28c. Injuny Wor M 1 creet, factory, office   | e, MD 207 ng, such as cardiad y ren in Part I.  26. Place of De. 1er: 4 \( \triangle \) Nursing H ry at k? Yes 2 \( \triangle \) No  | 23e. Did tobac  1  | 23d. Dat Mo co use contr 2 No 24b. \ d? \text{No} ce 6 \( \text{Oth} \) injury occurr et and Numb State)   | Approximate Interval Between Cnset and Death Cnset and Death Part of the Cause of death?  3 Probably Apular Unknow Were autopsy findings availal prior to completion of cause of death?  1 Yes 2 Now Noter (Specify)   |
| Funeral Director: After this certificate has been signed by the attending physician and polymeral briefly filled in by the funeral director, page 2 should be detached for use as the burial-transit and burial-transit.   | Certification: To Be Completed by Physician/Medical | shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1    Yes 2    No 9    Unknown  Part II. Other significant conditions co   | ilications that caused the cause on each line.  a. Sepsis  Due to (or as a Renal Fab.  Due to (or as a Gold Fab.  Due to (or as a | consequence of): ailure ailure consequence of): Renal Fai consequence of):  repregnancy Fetal death me of death for death solution in the understand solutio | Problems  Problems  Lure  Ectopic pregnancy Other (specify)  underlying cause giv  and 3 DOA Oth of 28c. Injury Wor 1 creet, factory, office  | ren in Part I.  26. Place of December: 4 \( \triangle \) Nursing Fry at K?  IYes 2 \( \triangle \) No  | 23e. Did tobac  1 Yes  24a. Was an autopsy performe 1 Yes  26th (Check only one)  1 Residence 28d. Describe how  28f. Location (Stree City or Town, \$                                   | 23d. Dat Mo  22 No  24b. Vd? No  24b. Vd? No  24b. Vd? And Numb  25tate)   | Approximate Interval Between Cnset and Death Cnset and Death Part of the Cause of death?  3 Probably Apular Unknow Were autopsy findings availal prior to completion of cause of death?  1 Yes 2 Now Noter (Specify)   |
| ire rector. After this certificate has been signed by the attending physician and up of solid by the funeral director, page 2 should be detached for use as the burial-transit and leading to by the funeral director, page 2 should be detached for use as the burial-transit.  | To Be Completed by Physician/Medical                | shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions | ilications that caused trine cause on each line.  a. Sepsis  Due to (or as a or as a correct of the correct of  | consequence of): ailure ailure consequence of): Renal Fai consequence of):  repregnancy Fetal death me of death for death solution in the understand solutio | Problems  Problems  Lure  Ectopic pregnancy Other (specify)  underlying cause giv  and 3 DOA Oth of 28c. Injury Wor 1 creet, factory, office  | ren in Part I.  26. Place of Dener: 4 \( \text{Nursing F} \) Yes 2 \( \text{No} \)  The state of the state of | 23e. Did tobact 1 Yes 24a. Was an autopsy performe 1 Yes 24d. Describe how 28d. Describe how 28f. Location (Street City or Town, \$250.00) e, and due to the causurred at the time, date | 23d. Date Mo  24b. Vol. (1)  24b. Vol. (2)  24b. Vol. (3)  24b. Vol. (4)  24b. Vo | Approximate Interval Between Cnset and Death Cnset and Death Death Day Year Probably 4 Unknow Were autopsy findings availaprior to completion of cause of death?  1 Yes 2 No No No Noter (Specify)  Tred  Der or Rural Route Number,   |

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State of Maryland / Department of Health and Mental Hygien

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|--------|----|---|---|---|
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|                |  |                  |   |  | •                   | Cert                   | ificate of                     | Death                          | ,                 | Reg. No.              |           | UYU  | ) L. U     |  |
|----------------|--|------------------|---|--|---------------------|------------------------|--------------------------------|--------------------------------|-------------------|-----------------------|-----------|--|------------|--|
|                | Division   |                  | 1. Decedent's Name (First, Middle, I  | ast)   |                     |                        |                                | <del></del>                    | 2. Date of Dea    | ath<br>Day            | Year      | 3. Time of                                   | Death      |  |
| . 0            | Physic<br>/Medi  |                  | James   | Wilmer I   | Digma               | an                     |                                |                                | Jan.              |                       | 800       | 6:30   | P.M.       |  |
|                | Exami  |                  | 4a Facility Name (If not institution, g   | ive street and number)                             |                     |                        |                                | 4b. City, Town, or Lo          | ocation of Death  | 4c. County            | of Death  |  |            |  |
|                |  | 1                | Garrett Count   | y Mem'l H  | lospi               | ital                   |                                | 0aklan                         |                   | Garr                  |           |  |            |  |
|                | • Funeral  |                  |   | Sex 7. Ag  |                     | st birthday)           | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min. | (Month, Da        | h<br>v, <i>Year</i> ) | 9. Birth  | place (State o                               | r Foreign  |  |
|                | Director   |                  | 232-26-9301 Usual Residence of Decedent   | 7 <del>2</del> 4                                   | 87                  | Yrs.                   |                                |                                | 09/29             | /1920                 | Tucl      | cer Co                                       | V,WV       |  |
|                | end w  |                  | 10a. State 10b. County  |  | 10c. City,          | Town or Loca           | ation                          |                                |                   |                       |           | 10d. Inside Ci                               | ity Limits |  |
|                | Manyl<br>f sho   | ō                | WV Tucke  | r  | Т                   | Leadmi                 | ino                            |                                |                   |                       |           | 1 🗆 Yes                                      |            |  |
|                | the 1  | 5                | 10e. Street and Number  | <u> </u>   |                     | beaum.                 | 10f. Zip Code                  |                                |                   | 10g. Citizen of V     | Vhat Cou  | ntry?  |            |  |
|                | With<br>Sa or  | Funerai Director | Rural Route 2   | Box 160  |                     |                        | 2628                           | 7                              |                   | USA                   |           | •  |            |  |
|                | ms 2   | era              | 11. Marital Status  | 12. Was Decedent                                   | Ever in U,S         | s. 13. W               | as Decedent of I               | lispanic Origin? (Sp           | ecify Yes or No   | 14. Race              |           | can Indian,                                  |            |  |
| 0              | fer c  | Ē                | 1 ☐ Never Married 2 ☐ Married   | Armed Forces?<br>1 X Yes 2 ☐ N<br>If Yes, Give     | 10                  | lf '                   | Yes, specify Cub               | an, Mexican, Puerto            | Rican, etc.)      | Blac                  | k, White, | etc.   |            |  |
| 05(            | urs a  | þ                | 3 X Widowed 4 □ Divorced  | If Yes, Give<br>Year or Dates:                     | 1943                | 11                     | □Yes 2XX No                    | Specify:                       |                   | Specify               | Whi       | ite  |            |  |
| 21215-0020     | within 72 hours after death with the Marylend<br>ene.<br>than "natural", or items 23s or 28s-f show<br>he M-dical Examines the motified at   | Completed        | 15. Decedent's (Specify only highest of   | Education  |                     | 16a. Decede            | nt's Usual Occup               | pation                         | ina               | 16b. Kind of Bu       | siness/Ir | dustry                                       |            |  |
| 2              | thin .   | npie             | Elementary/Secondary (0-12)   | College (1-4or 5                                   | +)                  |                        |                                | during most of work<br>d)      | ,,,g              | Buildi:<br>Constr     |           | on   |            |  |
|                | ed w<br>ygien<br>er th   | Co               | 12  |  |                     | Gener                  | al Cor                         | tractor                        |                   |                       |           | LOH  |            |  |
| pu             | tal H<br>d oth   | Be               | 17. Father's Name (First, Middle, Las   | -  |                     |                        |                                | 18. Mother's Name              |                   |                       | e)        |  |            |  |
| <u>\sqr</u>    | ould<br>Men<br>marka   | P                | Glenn Digm  |  | 1                   |                        |                                | Virgin                         |                   |                       |           |  |            |  |
| Maryland       | 12 sh<br>and<br>Is m   |                  | 19a. Informant's Name/Relationship  | •            | and Number or Run   |                        |                                |                                | •                 |                       |           |  |            |  |
|                | 1 and<br>Healtl  |                  | Linda Paulsor 20a. Method of Disposition  |  | 20h Pla             |                        |                                | Dr. Co                         | Lorado            | Spring                |           |  | 120        |  |
| ٥              | ages<br>intofl   |                  | 1 □ Burial 2 X Cremation 3  | Removal from State                                 |                     |                        |                                |                                |                   |                       |           |  |            |  |
| Baltimore,     | it. Partmentrant   |                  | 4 ☐ Donation 5 ☐ Other (Spec<br>21. Signature of Fuperal Service Lic  |  | Ume                 |                        | ı, WV                          |                                |                   |                       |           |  |            |  |
| Ba             | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the M-dical Examiner must be notified at once. |                  | 21. Signature of Funderal Service Lic   | 11.  | Home                |                        |                                |                                |                   |                       |           |  |            |  |
|                |  |                  | X/-SCOOL  | unkle  | : 186 Da            | vis, W                 | V 26260                        | )<br>)                         |                   |                       |           |  |            |  |
|                |  |                  | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List on  | nplications that caused<br>y one cause on each lir | the death.<br>ie.   | Do not enter           | the mode of dyi                | ng, such as cardiac            | or respiratory ar | rest,                 | İ         | Approximat<br>Interval Bet<br>Onset and I    | ween       |  |
| Ĭ.             | Physician L  |                  | Immediate Cause (Final  | D  |                     |                        |                                |                                |                   |                       |           |  |            |  |
|                | Examiner   |                  | disease or condition<br>resulting in death)   | a  | umon                |                        |                                |                                |                   |                       | 1         | 2 wee  | ks         |  |
|                | To the   | ē                |   | _  | bue to (or<br>hyse) | as a consequ<br>m a    | ence of):                      |                                | į.                | vears                 |           |  |            |  |
| 1              | uted<br>d<br>ansit   | Medicai Examiner | Constant the flat and state of  | l b  | ,                   | as a consequ           | ence of):                      |                                |                   | 1.                    | years     |  |            |  |
| oʻ             | requires that the death certificate be executed been signed by the attending physician end inouid be detached for use as the burial-transit  | Exa              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   |  | Due to (or t        | as a consequ           | 51100 017.                     |                                |                   |                       |           |  | 1          |  |
| 68760,         | ysicia<br>ysicia   | icai             | Cause (Disease or injury that initiated events  | C  | Due to (or a        | as a conseque          | ence of):                      |                                |                   |                       |           |  |            |  |
|                | ntifica<br>ng ph<br>as th  | Med              | resulting in death) Last  |  |                     |                        |                                |                                |                   |                       | il d      |  |            |  |
| Box            | attending for use  |                  |   | d  |                     |                        |                                |                                |                   |                       |           |  |            |  |
|                | the at   | Physician/       | Part II. Other significent conditions   | contributing to death bu                           | it not result       | ting in the und        | lerlying cause gi              | ven in Part I.                 | 23b. Did t        | obacco use cor        | tribute t | o the cause o                                | of death?  |  |
| P.0            | that the de<br>ed by the<br>detached   |                  | Chronic   | kidney d   | isea                | se                     |                                |                                | 101               | fas 2□ No             | 3□ Pro    | bably 4                                      | Unknown    |  |
|                | ires the<br>signed<br>d be de  | þ                |   |  |                     |                        |                                |                                |                   |                       | 0.4 h 14  | /ere autopsy f                               | Go dio - a |  |
| 0              | v require<br>been si<br>should   | etec             |   |  |                     |                        |                                |                                |                   | an autopsy<br>rmed?   | av        | vailable prior to<br>mpletion of o<br>death? | to         |  |
| 3ec            | 2 s  | Completed        |   |  |                     | *7                     | of                             | death?                         |                   |                       |           |  |            |  |
| <u>=</u>       |  |                  | at serve  | 1 🗆 ١  | ′es X□No            | 1                      | ☐ Yes 2☐                       | No                             |                   |                       |           |  |            |  |
| Vital Records, | Physician: The this certificete ral director, pag  | o Be             | 25. Was case referred to medical examiner? 1   Yes 2   X No   |  |                     |                        |                                |                                |                   |                       |           |  |            |  |
| of             | 두 두 등  | -                | 1 ☐ Yes 2 🔼 No 27. Manner of Death  |  | lence 6 Othe        |                        | ty)                            |                                |                   |                       |           |  |            |  |
| on             | ding F.<br>th.<br>After<br>funer   | tio              | 1 ☑Natural 5 ☐ Pending<br>2 ☐ Accident investigati  | 28a. Date of Injur<br>(Month, Day                  | Year)               | 28b. Time of<br>Injury | 28c. Inju<br>Wo<br>M 1         | rk?<br>Yes 2 □ No              |                   |                       |           |  |            |  |
| Division       | l or Attending I<br>efter death.<br>Director: After<br>I in by the funer   | fica             | 3 ☐ Suicide 6 ☐ Could not   | De Diana diana                                     | ıry - At hon        | ne, farm, stree        | et, factory, office            |                                | 28f. Location (S  | Street and Numb       | er or Run | al Route Num                                 | iber,      |  |
| Ö              | s effe   | Certification:   | 4 ☐ Homicide  | building, etc                                      | . (Ѕресіту)         |                        |                                |                                | City or Tow       | m, Statej             |           |  |            |  |
|                | To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the fun   |                  |   | hysician: To the best of miner: On the basis of    |                     |                        |                                |                                |                   |                       |           |  | ٠,         |  |
|                | tha H<br>in 24<br>the Fi   | ledicai          | one)  | and manner sta                                     | ted.                | on anwormive           |                                |                                |                   |                       |           |  |            |  |
|                | With<br>To 1   | Σ                | 29b. Signature and title of certifier   | 2/   |                     |                        | 29c. Licens                    |                                |                   | 29d. Date signed      |           | Day, Year)                                   |            |  |
|                | . \  | Į                | · (AL   |  | _                   |                        | D 23                           | 3979                           | 9 1.29.08         |                       |           |  |            |  |
|                | H  |                  | 30. Name and address of person who  |  |                     |                        |                                | 0.1.                           |                   |                       |           |  |            |  |
|                |  |                  |   |  |                     | 4th S                  | treet                          | 0akland                        | , MD              | 21550                 |           |  |            |  |
|                | St <i>a</i><br>Registr   |                  | TOWN A COMPANY OF THE PARTY OF |  |                     |                        |                                |                                |                   |                       |           |  |            |  |

Department of Health Important: If item 27 any Injury or other to once. **Physician** /Medical

Physician

/Medical

**Examiner** 

10a State

VA.

**Funeral** 

Director

or 28a-f show e notified at

ns 23a or 7 must be n

"natural", or items

Medical

Director

by Funeral

Completed

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

**Examiner** 

Examiner physician and sthe burial-trans Physician/Medical Be Completed by Certification: To

Division or Vital Records, P.O. Box 68760

| disease or condition resulting in death)   | a. Due to (or as a consequence of):  |   |
|--|--|---|
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. Preumenis Due to (or as a consequence of):  c. Preumotheras with R  Due to (or as a consequence of):  d. Supsis   | Noncho Pleural fistula:   |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown           | 23d. Date of delivery<br>Month Day Year   |
| Part II. Other significant conditions of   | ontributing to death but not resulting in the underlying cause given in F  | 1 Yes 2 No 3 Probably 4 Unknow  24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death? |
| 25. Was case referred to medical   | 26   | 1 Yes 2X No   1 Yes 2 No   No   No   No   No   No   No   No   |
| examiner?<br>1 □ Yes 2 <b>∑</b> No   | Hospital:  | □ Nursing Home 5 □ Residence 6 □ Other (Specify)  |
| 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation   | 28a. Date of Injury (Month, Day Year)  28b. Time of Injury  28c. Injury at Work?  1 ☐ Yes  | 28d. Describe how injury occurred   |
| 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State)   |
| 29a. Certifier 1 Certifying Ph<br>(Check only 2 Medical Examone)   | ysician: To the best of my knowledge, death occurred at the time, da niner: On the basis of examination and/or investigation, in my opinion and manner stated. | ate and place, and due to the cause(s) and manner as stated.  n, death occurred at the time, date and place, and due to the cause(s)        |

29c. License number

063839

<u>7600 Carroll Ave.Takoma Park,Md</u>

29d. Date signed (Month, Day, Year) 08

DHMH 17 Rev 1/2001

State

Registrar

To the Hospital or Attenct within 24 hours after death To the Funeral Director:

29b. Signature and title of certifier

PAdma

JAN 31

31. Date filed (Month, Day, Year)

MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

08-00693 UNK UNK

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State of Maryland / Department of Health and Mental Hygiene

2008 04327

|  |  | 1- For State Certificate of Death Reg. No.   |                                  |                                       |                                |                          |              |            |                    |                 |                           |  |  |  |  |
|--|--|--|----------------------------------|---------------------------------------|--------------------------------|--------------------------|--------------|------------|--------------------|-----------------|---------------------------|--|--|--|--|
| Physicia   |  | Decedent's Name (First, Middl  | e,Last)                          |                                       |                                |                          |              |            | Date of Dea        |                 |                           | 3. Time of Death                                     |  |  |  |
| ledical Exami  |  | DeWayne Robert   | Dunmore                          |                                       |                                |                          |              |            | Month<br>January 2 | Day<br>25, 2008 | Year                      | 0309 hrs   |  |  |  |
|  |  | 4a. Facility Name (if not institution  |                                  | umber)                                | 41                             | o. City, Town, o         | Location o   |            |                    |                 | unty of Dea               | th   |  |  |  |
| ,  |  | Prince George's Hosp   |                                  |                                       |                                | Cheverly                 |              |            |                    | Princ           | ce Georg                  | ge's   |  |  |  |
| Funeral  |  | 5. Social Security Number  | 6. Sex                           | 7. Age (In yrs. last                  | birthday)                      | If Under 1 Ye            |              |            | B. Date of Bi      | rth(MM/DD/      | YYYY) 9. B                | irthplace (State or                                  |  |  |  |
| Director   |  | 218025173  | 1 <sub>X</sub> M 2 F             | 2                                     | 37 Yrs.                        | Min.                     | 03/18        | /1970      | C                  | washington .C.  |                           |  |  |  |  |
|  | ŀ  | Usual Residence of Decedent  |                                  |                                       |                                | · · · · ·                |              |            |                    |                 |                           |  |  |  |  |
| яву  |  | 10a. State 10b. County   |                                  | 10c. City, To                         | wn or Locatio                  | าก                       |              |            |                    |                 |                           | 10d. Inside City Limits                              |  |  |  |
| <b>*</b>   | _ [  | M. 1 1 01 1  | _                                | White                                 | D10-1-                         |                          |              |            |                    |                 |                           | 1X Yes 2 No  |  |  |  |
| Aaryland<br>28a-f show<br>1 at once.   | ector  | Maryland Charle  10e. Street and Number  | ន                                | IMITTE                                | riain                          | 10f. Zip Code            |              | _          |                    | 10g. Citizen    | of What Co                | untry?   |  |  |  |
| th the Maryland<br>23a or 28a-f sho<br>notified at once  | <u>ĕ</u>   |  |                                  |                                       |                                |                          |              |            |                    | United          |                           |  |  |  |  |
| h the  |  | 4309 Castletowe  | er Court                         |                                       |                                | 20695                    |              |            | 1                  |                 |                           |  |  |  |  |
| h wit  | era  | 11. Marital Status  1 Never Married 2 M  | 12. Was De                       | cedent Ever in U.S.<br>Forces?        |                                | Decedent of H            |              |            |                    |                 | Race - Ame<br>White, etc. | erican Indian, Black,                                |  |  |  |
| death<br>or iter<br>must   | Funeral Dir  |  | , 1 63                           |                                       |                                | ., ., .,                 | , , , , , ,  |            | ,                  |                 |                           | -1-  |  |  |  |
| after<br>al",  | by   | 3 Widowed 4 Div  | orced If Yes, Give Ye            |                                       |                                | Yes 2X N                 |              |            |                    |                 | ecify: B1a                |  |  |  |  |
| hours after<br>'uatural'',<br>Examiner   |  | 15. Decedent's Education (Spe  | cify only highest gra            | ide completed) 16                     |                                | s Usual Occupa           |              |            |                    | 16b. Kind       | of Business               | s/Industry   |  |  |  |
| 72 h   | lete   | Elementary/Secondary (0-12)  | College (                        | 1-4 or 5+)                            |                                |                          | J. DO 110 1  | 0001000    | • 7                |                 |                           |  |  |  |  |
| 03(<br>ithin<br>ne.<br>r thr   | п  | 12   |                                  | D:                                    | isable                         | d<br>                    |              |            |                    |                 | vate                      |  |  |  |  |
| 215-0036<br>be filed within 7<br>rtal Hygiene.<br>rked other than<br>ent, the Medica   | Completed  | 17. Father's Name (First, Middle   | •                                |                                       |                                | 77                       |              | ,          |                    | Maiden Sur      | name)                     |  |  |  |  |
| 21:<br>be fill<br>rked<br>ent, 1   | Be   | Franklin D. Dur  |                                  |                                       |                                |                          | Della        |            |                    |                 |                           |  |  |  |  |
| b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leafth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once  | ဥ  | 19a. Informant's Name/Relations  |                                  |                                       |                                | Address (Stre            |              |            |                    |                 |                           |  |  |  |  |
| MD<br>d 2 shx<br>lith and<br>n 27 is<br>aumat  |  | Germaine Dunmon  | ce / Wife                        | · · · · · · · · · · · · · · · · · · · | 4309 C                         | astleto                  | wer C        | t. Wh      | ite P              | lains,          | , Mary                    | land 20695   |  |  |  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical   |  | 20a. Method of Disposition   | promote and the second           |                                       |                                | tion (Name of c          | emetery,     | [          | Date               | 20c. Loca       | ation - City              | or Town, State                                       |  |  |  |
| Baltimore,<br>permir. Pages I ar<br>Department of Her<br>Important: If ite   |  | 1 Burial 2 Cremation   | _                                | July State                            | matory or oth                  |                          |              |            | 10555              | L .             |                           |  |  |  |  |
| timen then then then then to or or or or or or or or or or or or or  |  | 4 Donation 5 Other S   | ecify:                           | Harmo                                 | ony Me                         | morial                   | e of English | 02/01      | /2008              | Lando           | ver.                      | Maryland   |  |  |  |
| Sal<br>ermi<br>Depar<br>mpo  |  | 21. In our of Funeral Server Licensee 22. Name and Address of Facility Pone Funeral Homes, P.A.  |                                  |                                       |                                |                          |              |            |                    |                 |                           |  |  |  |  |
|  |  | 23a. Part N Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval   |                                  |                                       |                                |                          |              |            |                    |                 |                           |  |  |  |  |
| Physician Maric J  |  | failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Gunshot Wounds a. Multiple Gunshot Wounds   |                                  |                                       |                                |                          |              |            |                    |                 |                           |  |  |  |  |
| aminer   | 1  |  |                                  |                                       |                                |                          |              |            |                    |                 |                           |  |  |  |  |
|  |  | or condition resulting in death)   | Due to (or as                    | a consequence of):                    |                                |                          |              |            |                    |                 |                           |  |  |  |  |
|  | L  | Sequentially list conditions,  | b                                | n                                     |                                |                          |              |            |                    |                 |                           | <del></del>  |  |  |  |
|  | Examiner   | if any, leading to immediate cause. Enter Underlying Cause   |                                  | a consequence of):                    |                                |                          |              |            |                    |                 |                           |  |  |  |  |
|  | аш   | (Disease or injury that initiated events resulting in death) Last  | Due to (or as                    | a consequence of):                    |                                |                          |              |            |                    |                 |                           |  |  |  |  |
| uted<br>nd<br>ransit   |  | broine rooming in dodning Labor  | d                                |                                       |                                |                          |              |            |                    |                 |                           |  |  |  |  |
| 760,<br>icate be executed<br>physician and<br>the burial - transit   | /Medical   | UNPENDED   | AMENDED                          |                                       |                                |                          |              |            |                    |                 |                           |  |  |  |  |
| 760,<br>ficate be<br>g physic<br>the bur   | Med  | IF FEMALE:   | 23c. If yes                      | , outcome of pregnar                  | ncy                            |                          |              |            |                    | 23d. D          | ate of deliv              | ery  |  |  |  |
| 387<br>rtific<br>ing p   | l/ue   | 23b. Was decedent pregnant in to<br>past 12 months?  | I LIVE                           | birth                                 |                                | al death 3               | Ectopic      | c pregnanc | у                  | Mo              | onth                      | Day Year   |  |  |  |
| OX 68<br>eath certifi<br>attending<br>for use as   | siciar   |  |                                  | nant at time of death                 | 5 Oth                          | ner (Specify)            |              |            |                    | 1               |                           |  |  |  |  |
| Box 68 le death certif the attending   | Phys   |  |                                  | nown                                  |                                |                          |              |            | 00 5               | 4-1-            |                           | to the course of desired                             |  |  |  |
| P.O. B<br>is that the d<br>gned by the   |  | Part II. Other significant condi-  | tions contributing               | to death but not resu                 | ulting in the u                | nderlying cause          | given in Pa  | art I.     |                    |                 |                           | to the cause of death?                               |  |  |  |
| ires that signed   | d by   |  |                                  |                                       |                                |                          |              |            | 1Y                 | es 2 V N        | 0 3 P                     | robably 4 Unknown                                    |  |  |  |
| ords, F<br>v requires<br>s been sig<br>should be   | Completed  |  |                                  |                                       |                                |                          |              |            | 24a. Wa            | s an<br>opsy    |                           | autopsy findings available to completion of cause of |  |  |  |
| e law  | ш  |  |                                  |                                       |                                |                          |              |            | perl               | formed?         | death                     | ?  |  |  |  |
| Re<br>i. The   |  | OF Mes some effect of the control of |                                  |                                       |                                | ne mi-                   | on of Death  | (Check an  | 1 Yes              | 2No             | 1 🗸                       | Yes 2 No   |  |  |  |
| ital<br>ician<br>certi   | Be   | 25. Was case referred to medica examiner?  | Hospital:                        | Institut 0.00                         | D/Oute =N=C*                   |                          | Other        |            | Home 5             | Residence       | 6 0                       | her:   |  |  |  |
| Physical diagrams  | 2  | 1 ✓ Yes 2 No   |                                  | Inpatient 2 🗸 El                      | R/Outpatient<br>8b. Time of Ir |                          | ury at Work  |            |                    | how injury      |                           | nor.   |  |  |  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funcral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi |  | 27. Manner of Death  1 Natural 5 Pop   | loc (Mop                         | th Day Year)                          | 86. Time of it<br>)159 hrs     |                          | ves 2 ✓      | - Is       | ubject sh          |                 | QUOUITEU                  |  |  |  |  |
| isior Attender death   | atic   |  | stigation                        | ace of Injury - At hom                |                                |                          |              |            | 06.1               | (0)             |                           | D ad David   |  |  |  |
| ivision or Attendafter death Director:   | tific  | 3 Suicide 6 Cou  | or Town,                         | (Street and State)                    | Number or                      | Rural Route Number, City |              |            |                    |                 |                           |  |  |  |  |
| Divis  | 27. Mailine of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 1. Suicide 6 Could not be determined 1. Suicide 6 Could not be determined 1. Specify Local Street 1. Suicide 6. Specify Local Street 1. Suicide 1. Suicide 6. Specify Local Street 1. Suicide 1. Suicide 6. Specify Local Street 1. Specify 1. Specify 1. Suicide 6. Specify 1. Spec |  |                                  |                                       |                                |                          |              |            |                    |                 |                           |  |  |  |  |
| Dir<br>To the Hospital of<br>within 24 hours at<br>To the Funcral I  |  |  |                                  |                                       |                                |                          |              |            |                    |                 |                           | tated.   |  |  |  |
| To the Ho<br>within 24 P<br>To the Fur   | Medical  | one) 2 Medical Exa   | miner:On the basis<br>and manner | s of examination and<br>stated.       | or investigat                  |                          |              |            | tne time, dat      |                 |                           |  |  |  |  |
| F \$ F ŏ   | Me   | 29b. Signature and title of certifi  |                                  | A                                     |                                | 29c. Lice                | se number    |            |                    | 29d. Dat        | e signed (/               | Month, Day, Year)                                    |  |  |  |
|  |  | 16.1.  |                                  |                                       |                                | 0.0                      | M.E.         |            |                    | Janua           | ry 25, 20                 | 008  |  |  |  |
|  |  | 30. Name and address of person   | who completed ca                 | us of death (It                       | 3a)**                          |                          |              |            |                    |                 |                           |  |  |  |  |
| 0 41   |  |  | Assistant Medi                   | V.                                    |                                | n Street, Ba             | ltimore, I   | MD 212     | 01                 |                 |                           |  |  |  |  |
|  | tate   | · ·  |                                  | Registrar's Signatae                  |                                |                          |              |            |                    |                 | -                         |  |  |  |  |
| Regis  | tr <u>ar</u>   | 31. Date filed (Month, Day Year) FEB 0 1 2008  | Kanne .                          | N ADO                                 | A. S.                          |                          |              |            |                    | DCA             | ME                        |  |  |  |  |
|  |  | 1 - 5  | 344                              |                                       |                                |                          |              |            |                    |                 |                           |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Americal State of Maryland / Department of Health and Mental Hygiene Registrar 24a per verb., g876 O2/14/08dbb Red. No. -Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2150 0 LeRoy Edward Divelbliss a 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1√2 M 2□ F Months Days Hours Min. 200-24-0646 Director 74 April 16, 1933 W Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Y☐Yes 2☐No Director WV Morgan Berkeley Springs 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 161 Ewing Street Apt.H Funeral 25411 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 1 Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Truck and Body Fenderman Automotive Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie Divelbliss ٩ Ethel Mason 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 94 Robinwood Lane Berkeley Springs, WV 25411
ace of Disposition (Name of Date 20c. Location - City or Town, State LaDonna VanDaniker/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stone Bridge Brethren 02/11/2008 Hancock, MD 22. Name and Address of Facility 141 West Main Street 21. Signature o Funeral Saviga Licensee Grove Funeral Home, PA Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Selvis Two week! /Medical Due to (o as a consequence of): Examiner (or as a consequence of) Sequentially list conditions if any, being to minimum cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical Stu IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide

The law requires that the death certificate be executed Box 68760 Ö ۵ Records, Division or Vital Physician: Hospital or Attending

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

3a or 28a-f sh t be notified

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ural", or items?

the Medical

If Item 27 Is marked other

s 1 and 2 should be fill I Health and Mental H tem 27 Is marked oth

Pages 1

Department or Important: If any injury or

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funeral director, page 2 should

certificate has

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After t

after death Director:

24 hours a

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filled in by

4 Homicide

(Check only one)

29b. Signature and title of certifier

FEB 14

2mmalo

Year) 2008

29a. Certifier

the detached

à

physician

"natural"

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, State

Medical

Registrar

1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

02-08-2008

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|            |   |                  | for<br>State<br>Registrar  | Otate of Maryland  |                       | tificate of                                      |  |  | eg. No.                    | 008                               | 04329  |
|------------|---|------------------|--|--|-----------------------|--|--|--|----------------------------|-----------------------------------|--|
| ř          | Physici   | an               | 1. Decedent's Name (First, Middle, La  |  |                       |  |  | 2. Date of Deat<br>Month                     | Day                        | 2008                              | 3. Time of Death   |
|            | /Medic  | al               | WALTER  4a. Facility Name (If not institution, given   |  | ERSON                 | 4h City Town o                                   | r Location of Death                          | JANUARY                                      | _                          | 2008<br>unty of Death             | 12:40P M   |
| )          | Examin  | er               | PRINCE GEORGE'S  |  |                       | CHEVE  |  |  | 1                          |                                   | EORGE 'S   |
|            | Funeral<br>Director   |                  | 5. Social Security Number 6. S 223–28–0972   |  | ast birthday)<br>Yrs. | If Under 1 Year<br>Months Days                   | 8. Date of Birth<br>(Month, Day,<br>OCT • 25 | Year)<br>1923                                | 9. Birthp<br>Coun<br>VIRG  | lace (State or Foreign<br>(TNIA   |  |
|            | /land<br>ow   |                  | Usual Residence of Decedent  10a. State  10b. County   | 10c. City  |                       |  | 1  | 0d. Inside City Limits                       |                            |                                   |  |
|            | e Mary  | ctor             | MD PRINCE (  | GEORGE'S C   | APITOL                | HEIGHTS  |  |  |                            |                                   | 1 Yes 2 No   |
|            | vith the  | Funeral Director | 10e. Street and Number   |  |                       | 10f. Zip Code                                    |  | 10   |                            | of What Coun                      | try?   |
|            | ns 23s  | eral             | 216 PEPPERMILL DI  | 12. Was Decedent Ever in U.  | S. 13. V              | 20743<br>Vas Decedent of H                       | lispanic Origin? (Sp<br>an, Mexican, Puerto  | ecify Yes or No-                             | USA<br>14.1                | Race - Americ                     | an Indian,   |
| 215-0035   | be filed within 72 hours after death with the Maryland ttal Hygiene.  dother than "natural", or items 23a or 23a-f show event, the Medical Examiner must be notified at | by               | 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced   | Armed Forces? 1 X Yes 2 □ No ARM If Yes, Give Year or Dates:                                   | Y                     | f Yes, specify Cub                               | an, Mexican, Puerto<br>Specify:              | Rican, etc.)                                 |                            | Black, White, ecify:              | etc.<br>BLACK  |
| <u>ဂ</u>   | "natuı  | Completed        | 15. Decedent's E<br>(Specify only highest gro  | ducation<br>ade completed)   | 16a. Deced            | lent's Usual Occup<br>kind of work done          | oation<br>during most of work<br>d)          | ing  | 16b. Kind o                | of Business/Inc                   | dustry   |
| 7          | within iene. than   | omp              | Elementary/Secondary (0-12) 6th  | College (1-4or 5+)   |                       |  | ພ<br>UPERVISOF                               |  |                            |                                   |  |
| פר         | be filed<br>Ital Hyg<br>id other<br>event,  | Be C             | 17. Father's Name (First, Middle, Last   | ")   |                       |  | 18. Mother's Nam                             |  |                            | •                                 |  |
| yland      | should b<br>ind Ments<br>marked<br>umatic e   | 70               | WADE DICKER  |  | T                     |  | MARY   |  | DICKI                      |                                   |  |
| , Mar      |   |                  | 19a. Informant's Name/Relationship (SANDRA SCOTT/DA  | AUGHTER  | 216 F                 | PEPPERMIL  |  | CAPITOL H                                    | HEIGH'                     | TS,MARY                           | ZLAND 20743  |
| more,      | Pages 1<br>ent of H<br>nt: If Itel<br>ry or otl   |                  | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Speci  | Removal from State   | emetery, ciren        | sition (Name of natory or other place)  NS CEMET | ce)<br>ERY 2/7/2                             |  |                            | on - City or To<br>ENHAM , M      | wn, State<br>IARYLAND                                    |
| Бап        | permit. Pages 1 and 2<br>Department of Health s<br>Important: If Item 27 It<br>any injury or other tra  |                  | 21. Signature of Funeral Service Lice  |  | I. B. JEN<br>LANDOVI  |  |  |  |                            |                                   |  |
| ,          | 恒星  |                  | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only  | nplications that caused the death  |                       |  |  |  |                            | KILAND                            | Approximate<br>Interval Between                          |
|            | Physician   |                  | Immediate Cause (Final disease or condition  | _a PNEUMONIA   |                       |  |  |  |                            |                                   | Onset and Death  |
|            | /Medical<br>Examiner  |                  | resulting in death)  | Due to (or as a consequ<br>SEVERE PERI   |                       | VASCIII.A  | R DISEASI                                    | 7  |                            |                                   |  |
|            |   | ler              | Sequentially list conditions, if any, leading to immediate   | <ul> <li>b. Due to (or as a consequence)</li> </ul>  | retice of).           |  |  |  |                            |                                   |  |
|            | cuted<br>nd<br>transit  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events                                | CHRONIC OBS  |                       | VE PULMO   | NARY DISE                                    | EASE   |                            |                                   |  |
| 50,        | rificate be executed<br>ng physician and<br>as the burial-transit   | al Ex            | resulting in death) Last   | Due to (or as a consequ  | ience of):            |  |  |  |                            |                                   |  |
| 09/8q      | ificate<br>g phys<br>as the   | Medical          |  | d  |                       |  |  |  |                            |                                   |  |
| C. BOX     | death cer<br>e attendir<br>d for use  | Physician/M      | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown | death 3               | Ectopic pregnanc<br>Other <i>(specify)</i>       | у  |  | 23d.                       | Date of delive<br>Month           | ery<br>Day Year  |
| 7 <u>.</u> | requires that the<br>een signed by th<br>nould be detache   |                  | Part il. Other significant conditions  | contributing to death but not resu   | ulting in the ur      | nderlying cause giv                              | ven in Part I.                               | 23e. Did tob                                 | acco use o                 | contribute to th                  | ne cause of death?                                       |
| cords,     | equires<br>en sign<br>ould be   | ed by            |  |  |                       |  |  | 1 □ Y€                                       | es 2∐N                     | lo 3□ Prob                        | abiy 4 XUnknown  |
| Heco       | sician: The law re<br>certificate has bee<br>irector, page 2 sho  | Completed        |  |  |                       |  |  | 24a. Was ar<br>autops<br>perforr<br>1□ Yes 2 | y<br>need?                 | prior to cor                      | psy findings available<br>mpletion of cause of<br>2 2 No |
| VITal      | ysician:<br>is certifica<br>director, p   | Be C             | 25. Was case referred to medical examiner?   | U - Star   |                       | 1  | 26. Place of Deat                            |  |                            | T L Tes                           | 20110  |
| 0          | this ald  | 은                | 1 ☐ Yes 2 ☐ No  27. Manner of Death  | Hospital: 1 ☐ Inpatient 2 🛣  | ER/Outpatien          | <del></del>                                      | 4 LI Nursing Ho                              | ome 5 Reside                                 |                            |                                   | y)   |
| slon       | ifter Ing   | tion             | 1 Natural 5 Pending 2 Accident investigatio  | (Month, Day Year)  | Injury                | Wor  | rk?<br> Yes 2 □No                            | 200. Describe no                             | w injury oc                | curred                            |  |
| DINIS      | To the Hospital or Attending F within 24 hours after death.  To the Funeral Director: After completely filled in by the funer.  | Certification:   | 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or F |  |                       |  |  |  |                            |                                   |  |
|            | e Hospita<br>24 hours<br>e Funera   | Medical C        | 29a. Certifier (Check only one)  | hysician: To the best of my knorminer: On the basis of examination and manner stated.          | wledge, death         | occurred at the ti                               | me, date and place,<br>opinion, death occur  | and due to the carred at the time, d         | ause(s) and<br>ate and pla | d manner as si<br>ace, and due to | tated.<br>the cause(s)                                   |
|            | To the To the comp  | Me               | 29b. Signature and title of certifier  | - 11h.   | JA.                   | 29c. Licens                                      |  |  |                            | gned (Month,                      |  |
| 0          | 5   |                  | 30. Name and address of person who   | completed cause of death (Item   | 23a) (Tyne            | D005   | / 042  |  | JANUA                      | 7KI 30                            | , 2008   |
| 1          | (6)   |                  | Anita Clayton M  |  |                       |  | go, Maryl                                    | and 2077                                     | 2                          |                                   |  |
|            | Sta<br>Registi  |                  | 31. Date filed (Month, Day, Year)<br>FEB 0 1 2008  | 32. Registrar's Signa  | ure                   |  |  |  |                            |                                   |  |
|            |   |                  | (LU V L STOR   | THE WAY  |                       |  |  |  |                            |                                   |  |

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|                            |  | ,                             | For<br>State<br>Registrar  | State of Maryla   |                                       | artment of<br>rtificate of                                  |   | nd Mental Hy                                | giene<br>Reg. No. 20           | 08 04330  |  |  |  |  |
|----------------------------|--|-------------------------------|--|---|---------------------------------------|---|---|---|--------------------------------|---|--|--|--|--|
|                            | Physici  |                               | Decedent's Name (First, Middle,  JOSETTE   | Last) DEMETRIU  | S                                     |   |   | 2. Date of D<br>Month<br>JANUAE             | eath<br>Dav                    | 3. Time of Death 3:15 A M   |  |  |  |  |
|                            | /Medio<br>Examir   |                               | 4a. Facility Name (If not institution, g   | give street and number)   |                                       | 4b. City, Town,   | or Location of D                                  |   | 4c. County                     |   |  |  |  |  |
|                            | Funeral<br>Director  |                               | 5. Social Security Number 212–49–9751 Usual Residence of Decedent  | . Sex 7. Age (In yr. 1  | s. last birthday)<br>Yrs.             | If Under 1 Year<br>Months Days                              |   | Hrs. 8. Date of Bi<br>(Month, D<br>JANUAL   | rth 1942<br>av. Year)<br>XY 30 | 9. Birthplace (State or Foreign<br>Country)<br>JAMATCA  |  |  |  |  |
|                            | Maryland -f show lied at   | tor                           | 10a. State 10b. County   |   | OWIE                                  | cation  |   |   |                                | 10d. Inside City Limits  Y☐ Yes 2☐ No   |  |  |  |  |
|                            | th with the<br>23a or 28a<br>ist be notif  | al Direc                      | 10e. Street and Number<br>883 ST. MICHAEL  | S DRIVE   |                                       | 10f. Zip Code 20721   |   |   | 10g. Citizen of V<br>USA       | Vhat Country?   |  |  |  |  |
| 9800                       | ges 1 and 2 should be filed within 72 hours after death with the Maryland<br>nt of Health and Mentat Hygiene.<br>If Item 27 is marked other than "natural", or Items 23a or 28a-f show<br>or other traumatic event, the Medical Examiner must be notified at | Completed by Funeral Director | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  | 12. Was Decedent Ever in Armed Forces?  1   |                                       | Was Decedent of<br>if Yes, specify Cu<br>1 ☐ Yes 2X No      |   | n? (Specify Yes or N<br>Puerto Rican, etc.) | o- 14. Race<br>Blac<br>Specify | ce - American Indian,<br>ck, White, etc.<br>y: BLACK  |  |  |  |  |
| Maryland 21215-0036        | d within 72 h<br>glene.<br>er than "natu<br>the Medical  | Completed                     | 15. Decadent's<br>(Specify only highest<br>Elementary/Secondary (0-12)<br>12th   | Education<br>grade completed)<br>College (1-4or 5+)   | (Give                                 | dent's Usual Occi<br>kind of work done<br>DO NOT use retire | upation<br>e during most o<br>ed)                 | f working                                   | 1                              | Kind of Business/Industry  PRIVATE  |  |  |  |  |
| /land                      | permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than amy Injury or other fraumatic event, the Meonce.  | To Be (                       | 17. Father's Name (First, Middle, La JOHN COLLINS  |   |                                       |   |   | Name (First, Middle<br>LYN AMBERS           |                                | ne)   |  |  |  |  |
|                            | and 2 sho<br>ealth and<br>n 27 is ma   |                               | 19a. Informant's Name/Relationship VANESSA CLARKE  | DAUGHTER  | 883 S                                 | ST. MICHA   | AELS DR   | or Rural Route Num<br>IVE BOWIE             | , MAÝRLANI                     | 20721   |  |  |  |  |
| Baltimore,                 | Pages 1<br>ment of Hi<br>ant: If Iter<br>ury or oth  |                               | 20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  CRAIGHEAD ANGLICAN CHURCH  20c. Location - City or To CRAIGHEAD, J   |   |                                       |   |   |   |                                |   |  |  |  |  |
| Balt                       | permit.<br>Depart<br>Import<br>any Inj<br>once.  |                               | 21. Signature of Fundamental Service Licensee  22. Name and Address of Facility J. B. JENKINS FUNER 7474 LANDOVER ROAD LANDOVER, MARYLAND  |   |                                       |   |   |   |                                |   |  |  |  |  |
|                            | Physician<br>/Medical<br>Examiner  |                               | 23a. Part1. Enter the disease, or complex tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a car) equence of): |   |                                       |   |   |   |                                |   |  |  |  |  |
| 8760,                      | certificate be executed ding physician and lise as the burial-transit  | dical Examiner                | Sequentially list conditions, if any leading L. Immediations cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b. Due to (or as a conse  |                                       |   |   |   |                                |   |  |  |  |  |
| O. Box 6                   | death certif<br>e attending<br>d for use as  | Physician/Medi                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome pf preg<br>1 ☐ Live birth 2 ☐ Fe<br>4 ☐ Pregnant at time of<br>9 ☐ Unknown | tal death 3                           | Ectopic pregnan Other (specify)                             | су  |   |                                | te of delivery<br>nth Day Year  |  |  |  |  |
| rds, P.                    | w requires that the<br>s been signed by the<br>should be detache   | by                            | Part II. Other significant condition   | s contributing to death but not re  | esulting in the u                     | nderlying cause g   | iven in Part I.                                   |   | tobacco use conti              | ribute to the cause of death?  3 ☐ Probably 4 ☐ Unknown                                       |  |  |  |  |
| al Reco                    | The law<br>ate has b   | Completed                     |  |   |                                       |   |   | 24a. Wa:<br>auto<br>per<br>1⊡ Yes           | opsy<br>formed?                | Were autopsy findings available<br>prior to completion of cause of<br>death?<br>I ∐Yes 2 ⅔ No |  |  |  |  |
| Division or Vital Records, | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.   | ation: To Be                  | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  27. Manner of Death  1 ☒ Natural 2 ☐ Accident  5 ☐ Pending investigal  | 28a. Date of Injury<br>(Month, Day Year)  | ER/Outpatier<br>28b. Time o<br>Injury | f 28c. Inj<br>M 1[  | ther: 4 □ Nursi<br>ury at<br>ork?<br>□ Yes 2 □ No |   |                                |   |  |  |  |  |
| Divis                      | Ital or Atturs after de ral Directure led in by t  | Certification:                | 3 ☐ Suicide 6 ☐ Could no<br>4 ☐ Homicide determin  | building, etc. (Spec  |                                       |   |   | City or To                                  | own, State)                    | er or Rural Route Number,   |  |  |  |  |
|                            | To the Hospital<br>within 24 hours a<br>To the Funeral<br>completely filled  | Medical                       | (Check only 2 Medical E:   | Physician: To the best of my k xaminer: On the basis of exami and manner stated.                | nowledge, deat<br>nation and/or in    | vestigation, in my  | opinion, death                                    | place, and due to the occurred at the time  | e, date and place,             | and due to the cause(s)   |  |  |  |  |
|                            | with con   | N                             | 29b. Signature and title of certifier  | 7. all-   |                                       | D389  | nse number  |   |                                | 30, 2008  |  |  |  |  |
| P                          | (6)  |                               | FOUAD M. ABBAS   |   | ELVEDER                               | Print)<br>E AVENUE  | # 206   | BALTIMORE                                   | ,MARYLAN                       | D 21215   |  |  |  |  |
| ı                          | Sta<br>Regist  |                               | 31. Date filed (Month, Day, Year)  FFR (1 2008)  | 32. Registrar's Sig   | nature                                |   |   |   |                                |   |  |  |  |  |

|  |                | For<br>State<br>Registrar  |  | State o  | ı Marylar                 |                  | artment of<br>rtificate of            |   | Mental Hy                              | ygiene<br>.Reg. No               | Z 11 11 7                     | 3 04331                                      |  |  |  |
|--|----------------|--|--|--|---------------------------|------------------|---------------------------------------|---|--|----------------------------------|-------------------------------|--|--|--|--|
| Physic   |                | 1. Decedent's Name Thomas  |  | , Last)<br>el Ellis,                                 | Sr.                       |                  |                                       |   | 2. Date of D<br>Month<br>Februa        | Day                              | , 2008                        | 3. Time of Death 4:20 P M                    |  |  |  |
| /Medi<br>Exami   |                | 4a. Facility Name (If  | not institution  | , give street and nu                                 |                           |                  |                                       | or Location of Dea                      | ath                                    |                                  | County of De                  |  |  |  |  |
|  |                | 22705  5. Social Security Nu   |  | 6. Sex   | 7. Age (In yrs.           | last birthdav    |                                       | onardtow                                |  | irth                             |                               | Mary's<br>birthplace (State or Foreign       |  |  |  |
| Funeral<br>Director  |                | 215-52-944   |  | 1⊠M 2□F  | 58                        | Yrs.             | Months Days                           |   |  | y 27 <b>,</b> 1                  | 949 Ma                        | Country)                                     |  |  |  |
| and  |                | Usual Residence of I   | Decedent<br>10b. County  |  | 10c. Cit                  | ty, Town or L    | ocation                               |   |  |                                  |                               | 10d. Inside City Limits                      |  |  |  |
| Maryii<br>-f sho<br>ied al   | tor            | Maryland   | St.  | Mary's   |                           |                  | Leonardt                              | own                                     |  |                                  |                               | 1 Yes 2 No                                   |  |  |  |
| or 28a   | Director       | 10e. Street and Num  | ber  |  |                           |                  | 10f. Zip Code                         |   |  | 10g. Citi                        | zen of What (                 | Country?                                     |  |  |  |
| 23a c<br>ust be  | ral            | 22705 Duke   | Street   |  |                           |                  |                                       | 20650                                   |  |                                  | USA                           |  |  |  |  |
| er des<br>items<br>oer m   | Funeral        | 11. Marital Status   | d OF More  | Armed Fo   |                           | .S. 13.          | Was Decedent of<br>If Yes, specify Cu | Hispanic Origin? (<br>ban, Mexican, Pue | (Specify Yes or N<br>erto Rican, etc.) | lo-                              | nerican Indian,<br>nite, etc. |  |  |  |  |
| urs aft  | þ              | 1 ☐ Never Marrie 3 ☐ Widowed   |  | ed 1 ☐ Yes<br>If Yes, Gi<br>Year or D                | ve                        |                  | 1 ☐ Yes 2 <mark>图 N</mark> o          | Specify:                                |  |                                  | Specify:                      | White  |  |  |  |
| 72 hor<br>natura<br>inal E   | eted           | (Special   | 15. Decedent   | 's Education<br>It grade completed)                  |                           | i (Give          | edent's Usual Occu                    | during most of w                        | orkina                                 | 16b. Kind of Business/Industry   |                               |  |  |  |  |
| within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23a or 28a-f show<br>ha Mdral Examiner must be notified at   | Completed      | Elementary/Secon   |  | College (  | 1-4or 5+)                 | life.            | O Mechanic                            | ed)                                     | .s.r.ar                                | Car                              | Dealers                       | hip  |  |  |  |
| filed v<br>Hygie<br>Whert  |                | 12<br>17. Father's Name (#   | First, Middle,   | Last)  |                           | Auc              | O Mechanic                            | 18. Mother's N                          | ame (First, Middl                      | e, Maiden                        | Surname)                      |  |  |  |  |
| lid be<br>fental<br>rked c   | To Be          | John Willi   | am Ellis   | s, Sr.   |                           |                  |                                       |   | Edna Mae 、                             | Jones                            |                               |  |  |  |  |
| 2 shou<br>and N<br>Is ma   |                | 19a. Informant's Name/Relationship ( <i>Type. Print</i> )  19b. Mailing Address ( <i>Street and Number or Rural Route Number, City of the Computer of Rural Route Number or Rural Route Nu</i> |  |  |                           |                  |                                       |   |  |                                  | r Town, State                 | , Zip Code)                                  |  |  |  |
| and and the selfth mm 27 her tr  |                | Brenda Lee Ellis / Wife 22705 Duke Street Leonardtown, MD 20650  20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - Ci   |  |  |                           |                  |                                       |   |  |                                  |                               |  |  |  |  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M. chal Examiner must be notified at once.                                   |                | 1 ☑ Burial 2 ☐   | □Cremation 3 □Removal from State   cemetery, crematory or other place) February 9, |  |                           |                  |                                       |   |  |                                  |                               | ·  |  |  |  |
| mit. P<br>partme<br>portan<br>Injury   |                | 21. Signature of Fur   | 1  | Leonardtown, Maryland                                |                           |                  |                                       |   |  |                                  |                               |  |  |  |  |
| an per   |                | Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate   |  |  |                           |                  |                                       |   |  |                                  |                               |  |  |  |  |
|  |                | 23a. Part 1. Enter the<br>shock, or hear   |  | Approximate<br>Interval Between<br>Onset and Death   |                           |                  |                                       |   |  |                                  |                               |  |  |  |  |
| Physician  |                | Immediate Cause (F<br>disease or condition<br>resulting in death)  |  |  |                           |                  | to Liver                              | & Splee                                 | n                                      |                                  |                               | Oliset and Death                             |  |  |  |
| /Medical<br>Examiner   |                | ,  |  |  | or as a consec            |                  | er of th                              | o Tuno                                  |  |                                  |                               | 16 Months                                    |  |  |  |
|  | je             | Sequentially list con if any, leading to import  | ditions,<br>mediate  | b. Due to  | (or as a consec           | quence of):      | er or th                              | e Lung                                  |  |                                  |                               |  |  |  |  |
| ecuted<br>ind<br>transit   | Examiner       | Due to (or as a consequence of):  Cause. (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):   |  |  |                           |                  |                                       |   |  |                                  |                               |  |  |  |  |
| ficate be executed<br>physician and<br>s the burial-transit  |                | readiling in deadily be  |  | Due to   | (or as a consequence of): |                  |                                       |   |  |                                  |                               |  |  |  |  |
| ificate<br>p phys<br>as the  | edic           | G G G G G G G G G G G G G G G G G G G  |  |  |                           |                  |                                       |   |  |                                  |                               |  |  |  |  |
| h certi<br>ending  | M/M            | IF FEMALE:<br>23b. Was decedent  |  |  | tcome pf pregn            |                  | ⊒Ectopic pregnan                      | CV.                                     |  |                                  | 23d. Date of c                | ,  |  |  |  |
| res that the death certif<br>igned by the attending<br>be detached for use as  | Physician/Me   | in the past 12 r<br>1 ☐ Yes 2 ☐<br>9 ☐ Unknown   |  |  | nant at time of           |                  | Other (specify)                       |   |  |                                  | Month                         | Day Year                                     |  |  |  |
| that the   |                | Part II. Other signific  | cant condition   | ns contributing to d                                 | eath but not res          | sulting in the u | Inderlying cause g                    | iven in Part I.                         | 23e. Did                               | I tobacco u                      | ise contribute                | to the cause of death?                       |  |  |  |
| quires<br>n sign   | d by           | Malnutr  | ition  |  |                           |                  |                                       |   | 1五                                     | Yes 2                            | □No 3□                        | Probably 4  ☐ Unknown                        |  |  |  |
| aw requii<br>is been s<br>2 should   | Completed      |  |  |  |                           |                  |                                       |   | 24a. Wa                                |                                  |                               | autopsy findings available                   |  |  |  |
| The lav  | mo.            |  |  |  |                           |                  |                                       |   | per<br>1 Yes                           | opsy<br>formed?<br>2 <b>K</b> No | death                         | o completion of cause of<br>?<br>es 2፟፟፟፟ No |  |  |  |
| stctan: The<br>certificate<br>rector, pag  | Be (           | 25. Was case referre   |  | Hospital:  |                           |                  | 10                                    |   | eath (Check only                       | one)                             |                               |  |  |  |  |
| Phys<br>r this<br>ral dir  | <u>ا</u>       | 1 ☐ Yes 2 ☒ ↑  |  | 28a. Date  |                           | ER/Outpatie      | III 3 DOA                             |   | Home 5 Res                             |                                  |                               | pecify)                                      |  |  |  |
| nding<br>tth.<br>r: Afte<br>e fune   | ation          | 1 ☑ Natural<br>2 ☐ Accident  | 5 Pending investig   | 1 '  | th, Day Year)             | Injury           | of 28c. Inj<br>W<br>M 1               | ork?<br>]Yes 2∐No                       |  | ,                                | ,                             |  |  |  |  |
| r Atte<br>er deg<br>recto  | Certification: | 3 ☐ Suicide<br>4 ☐ Homicide  | 6 ☐ Could r<br>determ  | 200. Flace   | e of injury - At h        | ome, farm, st    | reet, factory, office                 | •                                       |  | (Street an                       |                               | Rural Route Number,                          |  |  |  |
| pital o  |                | 200 Cartilla   | 1 187 0  | a Dhuaisian Tari                                     | host of my le-            | nulodao de-      | th conversed -+ *                     | time data cod 1                         |  |                                  |                               | as atotad                                    |  |  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Medical        |  |  | g Physician: To the<br>Examiner: On the b<br>and man |                           |                  |                                       |   |  |                                  |                               |  |  |  |  |
| To the To the comple   | Me             | 29b. Signature and t   | title of certifier   |  | 1                         |                  | 29c. Licer                            | nse number                              |  |                                  | -                             | onth, Day, Year)                             |  |  |  |
| $\mathcal{N}$  |                | 1/16   | TRY  | 771195   | J                         |                  |                                       | 5426                                    |  | 02,                              | /04/200                       | 08   |  |  |  |
| JE.  |                | 30. Name and addre   |  | who completed caus<br>Lookout Re                     |                           |                  | , ,                                   | tar Hass                                | an, M.D.                               |                                  | . –                           |  |  |  |  |
| St   | ate            | 31. Date filed (Monti  | h, Day, Year)  | 32.  | egistrar's Sign           |                  | town, MD                              | 20030                                   |  |                                  |                               |  |  |  |  |
| Regist   |                |  | FEB 0  | 5 2008   | See .                     | D. 19            |                                       |   |  |                                  |                               |  |  |  |  |

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|---|----|----|-----|----|-----|
|   | /N | le | di  | ca | ıl  |
| E | X  | an | niı | 1e | r   |
|   |    |    |     |    |     |
|   |    |    |     |    | - 1 |

| ,          |  |                | 1. Decedent's Name (First, Middle, La   | ast)   |                                 |   |   | 2. Date of Death<br>Month         | h<br>Day Year                       | 3. Time of Death                                   |  |  |
|------------|--|----------------|---|--|---------------------------------|---|---|-----------------------------------|-------------------------------------|--|--|--|
|            | Physicia<br>/Medic   |                | James Corneliu  | ıs Fenwick   |                                 |   |   | February                          |                                     | 7:40 a <sup>M</sup>                                |  |  |
| 1          | Examin   | 200            | 4a. Facility Name (If not institution, gi   | ve street and number)  |                                 | 4b. City, Town,   | or Location of Death                      |                                   | 4c. County of Dear                  | th   |  |  |
|            |  | - 1667         | Washington Advent   |  |                                 | Takoma  |   | T = 1 15111                       | Montgomer                           |  |  |  |
| £.         | Funeral  |                |   | Sex 7. Age (In yrs. 1 X M 2 ☐ F                                | last birthday)<br>Yrs.          | Months Days   | r If Under 24 Hrs.<br>s Hours Min.        | 8. Date of Birth<br>(Month, Day,  | Year) Co                            | hplace (State or Foreign buntry)                   |  |  |
|            | Director   | -              | 215-36-4105 Usual Residence of Decedent   | 68   |                                 |   |   | 03/07/19                          | Mary                                | yland  |  |  |
|            | ow at  |                | 10a. State 10b. County  | 10c. Cit   | ty, Town or Lo                  | ocation   |   |                                   |                                     | 10d. Inside City Limits                            |  |  |
|            | Mary<br>Ff sh<br>fied  | ģ              | Maryland St. Mary   | r's Rid  | σe                              |   |   |                                   | 1 ☐ Yes 2 No                        |  |  |  |
|            | r 28a  | Director       | 10e. Street and Number  | , D , RIEG   |                                 | 10f. Zip Code   |   | 10                                | 10g. Citizen of What Country?       |  |  |  |
|            | h wit  | ョ              | 48736 Seaside Roa   | ad   |                                 | 20680   |   |                                   | United Sta                          | tes  |  |  |
|            | ems<br>er mu   | Funeral        | 11. Marital Status  | 12. Was Decedent Ever in U                                     | I.S. 13.                        | Was Decedent of   | Hispanic Origin? (Spuban, Mexican, Puerto |                                   | 14. Race - Ame<br>Black, Whit       | rican Indian,                                      |  |  |
| 9          | or it  | 고              | 1 ☐ Never Married 2 Married   | Armed Forces?<br>1   |                                 | 1 □ Yes 2 No  | Specify:                                  |                                   |                                     |  |  |  |
| 8          | urai",   | d by           | 3 ☐ Widowed 4 ☐ Divorced  | Year or Dates:   | 10= Date                        | danka Harri Oan   |   |                                   |                                     | Lack   |  |  |
| 5-         | "nat   | lete           | 15. Decedent's E<br>(Specify only highest g   | Education<br>rade completed)                                   | (Give                           | edent's Usual Occ<br>e kind of work don<br>DO NOT use retir | upation<br>e during most of wor<br>red)   | king                              | lob. Kind of Business               | industry   |  |  |
| 21215-0036 | 2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at  | Completed      | Elementary/Secondary (0-12) 7   | College (1-4or 5+)   | Engin                           |   | /   |                                   | Education                           |  |  |  |
|            | filed y  | Be C           | 17. Father's Name (First, Middle, Las   | st)  | 1 0                             |   | 18. Mother's Nam                          | ne (First, Middle, N              |                                     |  |  |  |
| an         | Mental Mental arked o  | To B           | Ambrose Fenwick,  | Sr.  |                                 |   | Bertha                                    | Mae Tayl                          | or                                  |  |  |  |
| Maryland   | should<br>and Men<br>s marke<br>umatic   |                | 19a. Informant's Name/Relationship  |  | 19b. Maili                      | ing Address (Stree  |   |                                   | ; City or Town, State, .            | Zip Code)  |  |  |
|            | 1 and 2<br>Health a<br>em 27 is  |                | Vera D. Fenwick/W   | Vife   | Square Lan                      | e, Fores  | tville, MD                                | 20747                             |                                     |  |  |  |
| ore        | of He fitem  |                | 20a. Method of Disposition 1 X Burial 2 □ Cremation 3   |  | Place of Dispo<br>cemetery, cre | osition (Name of<br>ematory or other p                      | lace)                                     | Date 2                            | 20c. Location - City or             | Town, State  |  |  |
| <u>ï</u>   | Pag<br>nent<br>ant: i  |                | 4 □ Donation 5 □ Other (Spec  |  | . Peter                         | r_Claver  | Cem 02/0                                  | 9/2008 S                          | St. Inigoes                         | s, Maryland  |  |  |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |                | 21. Signature of Funeral Service Lice   |  |                                 | 2. Name and Add   | ome, P.A.                                 |                                   |                                     |  |  |  |
|            | 20 E 20  |                | Kyle S. Simons  |  |                                 |   | ardtown, M                                |                                   |                                     |  |  |  |
|            |  |                | 23a. Part1. Enter the disease, or con<br>shock, or heart failure. List onl  | mplications that caused the dea<br>ly one cause on each line.  | th. Do not en                   | iter the mode of d  | ying, such as cardiac                     | or respiratory arre               | est,                                | Approximate<br>Interval Between<br>Onset and Death |  |  |
| 1          | Physician  |                | Immediate Cause (Final disease or condition resulting in death)   | a. Myocardial  |                                 | tion  |   |                                   |                                     |  |  |  |
|            | /Medical<br>Examiner   |                | Todaking in adda.   | Due to (or as a consec   |                                 |   |   |                                   |                                     |  |  |  |
|            |  | 5              | Sequentially list conditions,   | b. Pulmonary E   |                                 | sm  |   |                                   |                                     |  |  |  |
|            | uted<br>I<br>Insit   | min            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | ·  |                                 |   |   |                                   |                                     |  |  |  |
| Ć          | ath certificate be executed ittending physician and or use as the burlal-transit   | Examiner       | resulting in death) Last  | Due to (or as a consec   | quence of):                     |   |   |                                   |                                     |  |  |  |
| Box 68760, | te be<br>ysicia<br>ie bur  | an/Medical     | •   | d  |                                 |   |   |                                   |                                     |  |  |  |
| 89         | rtifica<br>ng ph<br>as th  | Med            | IF FEMALE:  |  |                                 |   |   |                                   |                                     |  |  |  |
| Š          | ith ce<br>tendii<br>r use  | an/l           | 23b. Was decedent pregnant  | 23c. If yes, outcome pf pregn<br>1 ☐ Live birth 2 ☐ Fet        |                                 | □Ectopic pregnar  | псу                                       |                                   | 23d. Date of de<br>Month            | livery<br>Day Year                                 |  |  |
|            |  | sici           | in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4□Pregnant at time of o  | death 5                         | Other (specify)   |   |                                   | WOITH                               | Day Teal   |  |  |
| P.0        | law requires that the de<br>as been signed by the a<br>2 should be detached f  | Physici        | Part II. Other significant conditions   | contributing to death but not res                              | sulting in the I                | inderlying cause (  | niven in Part I                           | 23e Did tob                       | bacco use contribute t              | o the cause of death?                              |  |  |
| S,         | ires the signeral land   | þ              | Hypertension  | contributing to death put not les                              | sulting in the t                | andenying cause (   | given in rait i.                          |                                   |                                     | robably 4 🕅 Unknown                                |  |  |
| 0.00       | red  | eted           |   |  |                                 |   |   |                                   |                                     |  |  |  |
| Records,   | <b>hysician</b> : The law<br>his certificate has t<br>I director, page 2 s   | Completed      | Diabetes  | <del></del>  |                                 |   |   | 24a. Was at autops                | sy prior to med? death?             | utopsy findings available completion of cause of   |  |  |
| a          | n: The licate har, page  |                |   |  |                                 |   |   |                                   | 2 X No 1 ☐ Ye                       | s 2 □ No   |  |  |
| or Vital   | Physician:<br>this certifical  | Be             | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒No   | Hospital: 1 🔀 Inpatient 2                                      | TER/Outpatio                    | nt 20 004 C   | )thor:                                    | ath (Check only on                | ence 6 □Other <i>(Sp</i> e          | /f-/   |  |  |
| Ö          | D + B  | To             | 27. Manner of Death   | 28a. Date of Injury  | 28b. Time                       |   |   |                                   | ow injury occurred                  | acny)  |  |  |
| Ou         | Attending Phr<br>r death.<br>ector: After thi<br>by the funeral  | tior           | 1 ANatural 5 ☐ Pending<br>2 ☐ Accident investigati  | (Month, Day Year)<br>on  | Injury                          |   | /ork?<br>☐ Yes 2 ☐ No                     |                                   |                                     |  |  |  |
| Division   | Attendi<br>r death.<br>ector: A<br>by the fu   | ifica          | 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine  |  | nome, farm, st                  | treet, factory, offic                                       | e   | 28f. Location (St<br>City or Town | treet and Number or F               | Tural Route Number,                                |  |  |
|            | tal or<br>s afte<br>al Dir<br>ed in  | Certification: | , Literature  | ballarily, etc. (opec.   | ·· <b>y</b> /                   |   |   | 011) 01 10111                     | 1, 51010)                           |  |  |  |
|            | Hospit<br>4 hour<br>Funer<br>ely fill  |                | (Check only 2 Medical Ex  | Physician: To the best of my kn aminer: On the basis of examin |                                 |   |   |                                   |                                     |  |  |  |
|            | To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the   | Medical        | 29b. Signature and tiple of certifier   | and manner stated.   |                                 | 29c. Lice   | ense number                               | 2                                 | 9d. Date signed (Mon                | th. Dav. Year)                                     |  |  |
|            | <b>5</b>   | _              | 1/////  | 1-   |                                 |   |   |                                   | 29d. Date signed (Month, Day, Year) |  |  |  |
|            | · 0  |                | Man   | )  | - 22-) /T:                      | D251  | .62                                       |                                   | 02/04/2008                          |  |  |  |
|            | 49   |                | 30. Name and address of person wh   |  |                                 |   | ma Darata                                 | Manage 1                          | 20012                               |  |  |  |
| -4         | Sta  | te             | Inder Chawla, M. I  | 32 egistrar's Sign   |                                 | Tako  | ma rark,                                  | maryland                          | 20912                               |  |  |  |
|            | Regist   |                | FEB 0 6   | 2008   | B A                             | mark!   |   |                                   |                                     |  |  |  |

Physician /Medical Examiner

certificate be executed

Box 68760.

Division or Vital Records, P.O.

prmit. Pages 1 and 2 st Department of Health and Important: if item 27 is n any injury or other traun

**Physician** 

/Medical

Examiner

Director

þ

Completed

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**Funeral** 

Director

show

an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at

traumatic event, the

2 should be filed within 72 hours after n and Mental Hygiene.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit signed by the at Id be detached fo ✓ To the Hospital or Attending Physician 24 hours after death.
 ✓ To the Funeral Director: After this completely filled in by the funeral. Certification:

Physician/Medical

<u></u>

Completed

Medical

resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown 25. Was case referred to medical examiner? 1 ☐ Yes 2 📶 No

27. Manner of Death 1 Natural

2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

and manner stated. 29b. Signature and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be determined

D35497

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1122 OPAL CT. MAGERSTOWN A

State Registrar 31. Date filed (Month, Day, Year)

FEB 0 4 2008

strar's Signature

1 Inpatient

1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |                  | State Registrar  | State of Maryland  |  | nt of Health and<br>te of Death   | Reg                                  | ene 0 0 8  | 0433  |  |  |
|--|------------------|--|--|--|---|--------------------------------------|--|---|--|--|
| Physicia<br>/Medic<br>Examin   | al               | Decedent's Name (First, Middle, Last)     SAMES     4a. Facility Name (If not institution, give streen)  | et and number) Ralking   | 61/<br>2018 4b. City                             | RAY<br>Town, or Location of Dea   | 2. Date of Death Month Tan 3         | Day Year of Death  | <del></del>   |  |  |
| Funeral  | lei              | VA Relab & Este 5. Social Security Number 6. Sex   | noted Care Gr 7. Age (In yrs. last 82  | iter 6   | or 1 Year   If Under 24 Hrs<br>Days Hours Min   |                                      | Cor  | nplace (State or Fore<br>Intry)<br><b>nsylvania</b> |  |  |
| Director works   | _                | 201-18-9596  Usual Residence of Decedent  10a. State  10b. County  Maryland  Baltimore   | 10c. City, T   | own or Location                                  |   | bary 27                              | 160  | 10d. Inside City Lim 1 ☐ Yes 2X                     |  |  |
| with the market  | Funeral Director | 10e. Street and Number  1621 Howard Avenue   |  |  | p Code<br>21221   | 100                                  | 10g. Citizen of What Country?  |   |  |  |
| Swittin / Z. Hours after Death with the Maryland<br>Jene<br>Triban "natural", or Items 23a or 28a-f show<br>The Madical Exeminer must be notified at | by               | 1 Never Married 2 Married 3 Widowed William Divorced   |  | 1 ☐ Yes<br>6a. Decedent's Us                     | Jal Occupation  | 16                                   | 14. Race - Amer<br>Black, White<br>Specify:<br>6b. Kind of Business/I      | e, etc.   |  |  |
| Hygiene.<br>ther than "  | e Completed      | (Specify only highest grade of Elementary/Secondary (0·12)  12  17. Father's Name (First, Middle, Last)  | ompleted) College (1-4or 5+)   | (Give kind of w<br>life. DO NOT<br>Steelwor      | ker   | rme (First, Middle, Ma               | Steel (  | Company   |  |  |
| • <u>6</u> 5 5   | To Be            | James P. Gray  19a. Informant's Name/Relationship (Type,   | Print)   | 19b. Mailing Addres                              | Bert  | rude H.  Rural Route Number, (       |  |   |  |  |
| Deportment of Health and Mering Popular in Item 27 is marke any injury or other traumatic once.  |                  | Linda L. Mitchall  20a. Method of Disposition  1   | 20b. Plac  | e of Disposition (N. etery, crematory or emation | Howard Ave ame of other place) 2/6 Society of and Address of Facility instampfor 15. Church | /2008<br>F PA Ha                     | arrisbur<br>Home, In   | Town, State  g, PA  C.                              |  |  |
| hysician<br>Medical<br>xaminer   |                  | 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, | Due to (or as a consequen  | Do not enter the ma                              |   |                                      |  | Approximate<br>Interval Betwee<br>Onset and Deat    |  |  |
| ate has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit   | dical Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last                       | Due to (or as a consequer  |  |   |                                      |  |   |  |  |
| by the ettending ph<br>tached for use as t   | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1  Yes 2 No 9 Unknown   | . If yes, outcome of pregnancy<br>1 □ Live birth 2 □ Fetal de<br>4 □ Pregnant at time of deat<br>9 □ Unknown | ath 3 Ectopic                                    |   |                                      | 23d. Date of del<br>Month  | ive <b>ry</b><br>Day Yea                            |  |  |
| been signed t  | þ                | Part II. Other significant conditions contri<br>Chromic Obstr  | uctive F   | ng in the underlying                             | cause given in Part I.  Any Diser   |                                      | acco use contribute to<br>s 2 □ No 3 Pr                                    | the cause of deat                                   |  |  |
|  | e Completed      | Chronic Kidn 25. Was case referred to medical  | ey Fail  | ne   | 00 00   | 1□ Yes 🎝                             | topsy prior to completion of cause death?                                  |   |  |  |
| r this   | ToB              | examiner? 1 Yes 2 No  27. Manner of Death Natural 5 Pending  |  | NOutpatient 3 1<br>Bb. Time of Injury            | Other /   | Home 5 ☐ Resider                     | sck only one)  S Residence 6 Other (Specify)  Describe how injury occurred |   |  |  |
| iter deat<br>Director:<br>in by the  | Certification:   | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Injury - At home building, etc. (Specify)  |  | <u> </u>  | 28f. Location (Str.<br>City or Town, | eet and Number or Ri<br>State)   | ural Route Number                                   |  |  |
| Within 24 hours after  | Medical          | (Check only 2 Medical Examine one)   | r: On the best of my knowle<br>r: On the basis of examination<br>and manner stated.                          | n and/or investigation                           | d at the time, date and placen, in my opinion, death oci                                    | curred at the time, da               | te and place, and due  | to the cause(s)                                     |  |  |
| \$ 1 K   | ×                | 29b. Signature and title of certifier  30. Name an address of person who com   | M.D.   | 3a) (Type, Print)                                | D56508<br>XIANCRIM<br>LTIMORE   | 5 SHA                                | Date signed (Mont  | 2008  |  |  |
| ∽√.  | ate              | 3900 LOCH RA 31. Date filed (Month, Day, Year) FEB 0 4 2008  | VEN BLV L<br>32. Agistrar's Signatur   | D. BA  | LTIMORE   | , MD                                 | 21218  |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** John William Goldsborough 2008 TEBRUARY 1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Anne Arundel Glen Burnie If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, July 30, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Mary land 66 213-46-7199 1941 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show at 1 ☐Yes XX No other traumatic event, the Medical Examiner must be notified Directo Crownsville Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USA 21032 or items 23a 1454 Fairfield Loop Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo 2 Specify: White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Family Farm Farm Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anne Loretta Abell ဥ Joseph Preston Goldsborough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 39894 Big Chestnut Road, Leonardtown, Maryland 20650 Al Saunders / Brother In-Law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) February 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 7, 2008 Hollywood, Maryland St. John's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 prolesses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ULMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has perform or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Man r of Death within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral. 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di i 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. title of certifle 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a

State

Registrar

ate 31. Date filed (Month, Day, Year)

and address of person who completed

0

FEB 0 6 2008

edicause of death (Item 23a) (Type, Print)

Len & foll

200

**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

08-00949

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Donald Garfield Holton

2008 04338

|   |                | 1- For State Certificate of Death Reg. No.                        |                                   |                    |                          |         |                  |           |                   |               |  |                 | _           |               |  |        |
|---|----------------|---|-----------------------------------|--------------------|--------------------------|---------|------------------|-----------|-------------------|---------------|--|-----------------|-------------|---------------|--|--------|
| Physici   |                | Decedent's Name (First, Midd                                      | . ,                               |                    |                          |         |                  | -         |                   | 2             | Date of Death     Month Day Year     A DE 2 have |                 |             |               |  |        |
| ledical Exami   | ner            | Donald Garf   | ield Holt                         | on                 |                          |         |                  |           |                   |               | February   | 2, 20           | 08          |               | 1853 hrs   |        |
| , the   |                | 4a. Facility Name (if not institution                             | -                                 | umber)             |                          | 41      | b. City, Town    | n, or L   | ocation of        | Death         |  |                 | c. County o |               |  | _      |
|   |                | 28270 Three Notch R   | oad                               |                    |                          |         | Hughes           | /ille     |                   |               |  | - 18            | St. Mary    | S             |  |        |
| Funeral   |                | 5. Social Security Number   | 6. Sex                            | 7. Age (In yrs     | last birthday            | /)      | If Under 1       |           | If Under          |               | 8. Date of Bi                                    | rth (MM         | /DD/YYYY    | 9. Birt       | hplace (State or                                 | $\neg$ |
| Director  |                | 217-44-5807   | 1 X M 2 F                         | 61                 |                          | Yrs.    | Months           | Days      | Hours             | Min.          | Apri1  | 1,              | 1946        | Foreig        | District of Unitry Columbia                      |        |
|   |                | Usual Residence of Decedent                                       |                                   |                    |                          |         | <u></u>          |           |                   |               | l  |                 |             | L             | COTUMBIA   | 7      |
| any   |                | 10a. State 10b. County  |                                   | 10c. Ci            | ty, Town or L            | ocatio  | n                |           |                   |               |  |                 |             |               | 10d. Inside City Limits                          | ,      |
| nd<br>CC.   | _              | Maryland  | Charles                           |                    |                          |         |                  | Hu        | ghesv             | 7 <b>i</b> 11 | ρ.   |                 |             |               | 1 Yes 2 X No                                     | )      |
| Maryland<br>28a-f show any<br>d at once.  | 양              | 10e. Street and Number  |                                   |                    |                          | _       | 10f. Zip Co      |           | 8                 |               |  | 10a. Cit        | izen of Wh  | at Cour       | trv?   | 4      |
| th the Maryland<br>23a or 28a-f sho<br>notified at once.  | Director       | 6615 Wimbush  | 6615 Wimbush Drive 20637          |                    |                          |         |                  |           |                   |               |  |                 |             |               | .,   |        |
| ith tl  | je.            | 11. Marital Status  | 2003,                             |                    |                          |         |                  |           |                   |               |  |                 |             | USA           | can Indian, Black,                               |        |
| ath v<br>items  | Funeral        |   | larried Armed F                   | orces?             |                          |         | s, specify O     |           |                   |               |  | J-              | White       |               | can indian, black,                               |        |
| i, or   |                | 3 Widowed 4 X Div   | 1 Yes                             | 2 X No             |                          | Π.      | Yes 2X           | No        | 2200#4            |               |  |                 | Specify:    | В1            | ack  |        |
| ns af<br>ural   | l by           | 15. Decedent's Education (Spe                                     | or Dates:                         |                    |                          |         | s Usual Occ      |           |                   | nd of wo      | rk done  | 116h            | Kind of Bus | iness/li      | odustry  | _      |
| 2 hou<br>"nat   | Completed      | Elementary/Secondary (0-12)                                       |                                   | 1-4 or 5+)         | durir                    | ng mo   | st of working    | g life. [ | DO NOT u          | se retire     | d)   | 1               |             | 1111000/11    | idusti y   |        |
| 36<br>hin 7<br>than<br>dical  | ple            | 12  | oonogo (                          | 1 4 01 0 1)        | Gro                      | un      | ds Kee           | epe:      | r                 |               |  |                 | tate        | Y             |  |        |
| d with  | ,om            | 17. Father's Name (First, Middle                                  | Last)                             |                    |                          |         |                  | 118       | 8 Mother's        | Name (        | First, Middle,                                   |                 | etera       |               | lome   | _      |
| al Hy   | Be             | James Edward  |                                   |                    |                          |         |                  | "         | J., WOLITON D     |               |  |                 |             |               |  |        |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than  | 0              | 19a. Informant's Name/Relations                                   |                                   |                    | 19b. Ma                  | ailina  | Address (S       | Street :  | and Numb          |               | ary Ce   |                 |             |               |  | _      |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once  |                | Carolyn Theresa G   | , , , , ,                         | htor               | - 16                     |         | imbush           |           |                   |               | esville.   |                 |             | i, State,     | Zip Code)  | 1      |
| and and fealth tem  |                | 20a. Method of Disposition  | reen / badg.                      |                    | o. Place of Dis          |         |                  |           |                   |               | Date   |                 |             | City or       | Town, State                                      | _      |
| Orc<br>Orc<br>For Friends   |                | 1 X Burial 2 Cremation  | n 3 Removal f                     | rom Ctoto          | crematory on<br>narles M | or othe | er place)        |           | - 1               |               | ıary 8,  | 10              | on owd+     |               | Managal d  |        |
| ti Pa<br>t. Pa<br>tmen<br>rtant   |                | 4 Donation 5 Other S  |                                   |                    |                          |         |                  |           |                   | 20            | 08   | LE              | onarut      | own,          | Maryland   |        |
| Baltimore, permit. Pages I ar Department of Hee Important: If ite   |                | 21. Signature of Funeral Service                                  |                                   | 2 -                |                          |         | ame and Ado      |           |                   | er Fi         | neral H  | Ome             | РΔ          |               |  |        |
|   |                | 11 publice  | <del></del>                       | mer                |                          | Р.      | O. Box           | 27        | 0 Le              | eonar         | dtown. 1   | MD 20           | 0650        |               |  | -      |
| Physician<br>/Medical   |                | 23a. Part I. Enter the disease, or failure. List only one cause   | on each line.                     | caused the dea     | th. Do not en            | ter the | e mode of dy     | /ing, si  | uch as car        | diac or r     | espiratory ar                                    | rest, sh        | ock, or hea | ırt           | Approximate Interval<br>Between Onset and        |        |
| xaminer   |                | Immediate Cause (Final disease                                    |                                   |                    |                          |         |                  |           |                   |               |  |                 |             |               | Death  | Ĵ      |
|   |                | or condition resulting in death)                                  | Due to (or as                     | a consequence      | of):                     |         |                  |           |                   |               |  |                 |             |               |  |        |
|   | -              | Sequentially list conditions, if any, leading to immediate        | b                                 | a consequence      | of):                     |         |                  | _         |                   |               |  |                 |             | _             |  |        |
|   | 틜              | cause. Enter Underlying Cause                                     |                                   | a consequence      | : 01).                   |         |                  |           |                   |               |  |                 |             |               |  |        |
|   | Examiner       | (Disease of injury that initiated events resulting in death) Last | Due to (or as                     | a consequence      | of):                     |         |                  |           |                   |               |  |                 |             |               |  | _      |
| recuted<br>and<br>transit   |                |   | d                                 |                    |                          |         |                  |           |                   |               |  |                 |             |               |  |        |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit | n/Medical      | UNPENDED  | AMENDED                           |                    |                          |         |                  |           |                   |               |  |                 |             |               |  |        |
| ords, P.O. Box 68760, w requires that the death certificate be ex s been signed by the attending physician should be detached for use as the burial   | 8              | IF FEMALE:  |                                   | outcome of pre     |                          |         |                  |           | _                 |               |  | 23              | d. Date of  | delivery      |  | П      |
| 68.<br>Sertifi  | ja n           | 23b. Was decedent pregnant in the past 12 months?                 | I Live                            | birth              | 1 11-                    | Feta    | al death         | 3         | Ectopic           | oregnand      | СУ   |                 | Month       | D             | ay Year  |        |
| Box<br>e death c<br>the atten   | Sic            | 1 Yes 2 No 9 Uni  | known g Unkn                      | nant at time of    | death 5                  | Othe    | er (Specify)     |           |                   |               |  | 160             |             |               |  | 3      |
| the d   | Physicia       | Part II. Other significant condit                                 |                                   |                    | t resulting in t         | he un   | derlying car     | ise niv   | en in Part        | 1             | 23e Did t  | ohacco          | use contril | nute to t     | he cause of death?                               | _      |
| P.O.  | þ              |   |                                   |                    | . roouning               |         | a city in ground | .00 g.v   | on mir on         |               |  |                 |             |               | ably 4 Unknown                                   |        |
| FS,<br>quire<br>en sig  | Completed      |   |                                   |                    |                          |         |                  |           |                   |               | 24a. Was   | 25              | Dilly-      |               |  |        |
| OFC<br>aw re<br>as be   | 읦              |   |                                   |                    |                          |         |                  |           |                   |               | auto   | psy             | p           | rior to c     | opsy findings available<br>ompletion of cause of | 3      |
| Rec<br>The I  | ĕ              |   |                                   |                    |                          |         |                  |           |                   |               | 1 V Yes  | rmed?<br>2 1    |             | eath?<br>✔ Ye | s 2 No   |        |
| of Vital Records, ng Physician: The law require the tribic certificate has been simeral director, page 2 should by  | Be             | 25. Was case referred to medica                                   |                                   | <u> </u>           |                          |         | 26.F             |           | of Death (C       | heck on       | ly one)  |                 |             | _             |  | _      |
| Vit<br>nysica<br>this c   | P              | examiner?<br>1 ✓ Yes 2 No   | Hospital: 1                       | Inpatient 2        | ER/Outpat                | ient    | 3 DOA            | 0         | ther <sub>4</sub> | Nursing       | Home 5   | Reside          | ence 6 🗸    | <b>O</b> ther | Scene  |        |
| n of ing Pl   | <u> </u>       | 27. Manner of Death   | 28a. Date                         | of Injury          | 28b. Time                | of Inj  | ury 28c.         | Injury    | at Work?          |               | 8d. Describe                                     |                 |             |               |  | _      |
| Division<br>tal or Attendir<br>13 after death.<br>14 Director: A  | 흹              | 1 Natural 5 Pend<br>2 ✓ Accident Inves                            | ing                               | Dav, Year)<br>2008 | 1852 hrs                 | ;       | 1[               | Ye        | s 2 🗸 N           | 10 P          | edestrian  | STruci          | k by auto   | )             |  |        |
| VISION At At Birect in by   | اق             |   | d not be                          | ce of Injury - At  | home, farm,              | street  | factory, offi    | ce bui    | lding, etc.       | 2             | 8f. Location (                                   | Street a        | and Numbe   | r or Ru       | al Route Number, City                            |        |
| Distal curs at Illed  | Certification: |   |                                   | Major Ro           | ad                       |         |                  |           |                   | 28            | or Town, 3<br>3270 Three                         | State)<br>Notch | Road, Hu    | ighesv        | ille, MD   | Į      |
| Hosp<br>24 hc<br>Fund<br>tely f   |                | 29a. Certifier 1 Certifying Pl                                    | nysician: To the be               | st of my knowle    | edge, death o            | ccurre  | ed at the time   | e, date   | and place         |               |  |                 |             |               |  |        |
| Division To the Hospital or Attend within 24 hours after death To the Funeral Director:   | Medical        |   | miner:On the basis<br>and manners |                    | and/or inves             | tigatio | on, in my opi    | nion, c   | death occu        | rred at t     | he time, date                                    | and pla         | ace, and du | e to the      | e cause(s)                                       |        |
| F 3 F 8   | §              | 29b. Signature and title of certifie                              |                                   | tateu.             |                          |         | 29c. Lic         | ense      | number            |               |  | 29d.            | Date signe  | d (Mor        | th, Day, Year)                                   | _      |
|   |                | ()  | Pan n                             | 12                 |                          |         | 0                | .C.M      | .E.               |               |  | Feb             | oruary 3,   | 2008          |  |        |
| 1   |                | 30. Name and address of person                                    | who completed care                | se of death (Ite   | em 23a)                  |         |                  |           |                   |               |  | J               |             |               |  | _      |
| 7   |                | Patricia Aronica-Pollal   | •                                 | ant Medica         | ,                        | r '     | 111 Penn         | Stre      | et, Balt          | imore.        | MD 2120  | 1               |             |               |  |        |
| St  | ate            | 31. Date filed (Month, Day, Year)                                 | 32.                               | gistrar's Signa    |                          |         | -0 Y             |           |                   | ,             |  |                 |             |               |  | 4      |
| Regist  |                | FEB 0 8   |                                   | Mary 1             | B. A                     | 401     |                  |           |                   |               |  |                 |             |               |  |        |
| DHMH 17 Rev 1/20  | 001            | ,   |                                   |                    | ORIGII                   | NAL     |                  |           |                   |               |  |                 |             |               |  | _      |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

|                |  |                | For<br>State<br>Registrar  | State of Marylan   |                        | artment of F                             |                               | nd Me                      |                               | jiene                          | 8 NL339                                    | }        |
|----------------|--|----------------|--|--|------------------------|--|-------------------------------|----------------------------|-------------------------------|--------------------------------|--|----------|
| Ε              | A  | 9              | Decedent's Name (First, Middle,  | Last)  |                        |  |                               | 2                          | 2. Date of Dea                | th                             | 3. Time of Death                           | _        |
| B.44           | Physici<br>/Medic  |                | John Phi   | llip Hill  |                        |  |                               |                            | Month<br>Tanuary              | Day Yea 7 25, 2008             | A.A.                                       |          |
|                | Examir   |                | 4a. Facility Name (If not institution,                                   |  |                        | 4b. City, Town, o                        | or Location of                |                            | January                       | 4c. County of De               |  |          |
|                |  |                | Spring Time Hom  |  |                        | Bowie                                    |                               |                            |                               |                                | George's                                   |          |
|                | Funeral<br>Director  |                | 5. Social Security Number 579–26–0245                                    | 5. Sex 7. Age (In yrs. I   | ast birthday)<br>Yrs.  | If Under 1 Year<br>Months Days           | If Under 2<br>Hours           | Min.                       | B. Date of Birth (Month, Day) | , Year) (                      | irthplace (State or Foreign<br>Country)    |          |
|                |  |                | Usual Residence of Decedent  | 81   |                        |  |                               | S                          | ept. 6                        | , 1926 Was                     | shington, DC                               | _        |
|                | nyland<br>how<br>at  |                | 10a. State 10b. County   | 10c. City  | , Town or Lo           | cation                                   |                               |                            |                               |                                | 10d. Inside City Limits                    |          |
|                | e Ma<br>3a-f s<br>tiffied  | Director       | Maryland Prince  | e George's   | Bowie                  |  |                               |                            |                               |                                | 1 X Yes 2 □ No                             |          |
|                | or 2%  | Dire           | 10e. Street and Number   |  |                        | 10f. Zip Code                            |                               |                            | 1                             | 0g. Citizen of What (          | Country?                                   |          |
|                | s 23a  | eral           | 12506 Chalford   |  | 0 40                   | 20715                                    |                               |                            |                               | United St                      |  |          |
|                | ter de<br>item<br>iner r   | Funeral        | 11. Marital Status 1 ☑Never Married 2 ☐ Married                          | 12. Was Decedent Ever in U.: Armed Forces?   | S. 13. V               | Was Decedent of H<br>If Yes, specify Cub | lispanic Orig<br>an, Mexican, | gin? (Speci<br>, Puerto Ri | fy Yes or No-<br>can, etc.)   | 14. Hace - An<br>Black, Wh     |  |          |
| 936            | urs af   | by             | 3 ☐ Widowed 4 ☐ Divorced   | d 1 Mayes 2 □ No<br>If Yes, Give<br>Year or Dates:   |                        | 1 □ Yes 2 No                             | Specify:                      |                            |                               | Specify:                       | African<br>merican                         |          |
| 21215-0036     | 72 hor   | Completed      | 15. Decedent's<br>(Specify only highest                                  | Education  | 16a. Dece              | dent's Usual Occup                       | oation                        | -6                         |                               | 16b. Kind of Busines           |  |          |
| 2              | ithin 7  | nple           | Elementary/Secondary (0-12)  | College (1-4or 5+)   | life. I                | kind of work done<br>DO NOT use retire   | d) auring most                | or working                 | '                             |                                |  |          |
|                | e filed within 72 hours after death with the Maryland<br>al Hygiene.<br>other than "natural", or items 23a or 28a-f show<br>vent, the Medical Examiner must be notified at   |                | 12 years   |  | Gov                    | vernment                                 |                               |                            |                               | Governme                       | ent  | _        |
| and            | ntal He fi   | Be             | 17. Father's Name (First, Middle, La                                     | ist)   |                        |  |                               |                            |                               | Maiden Surname)                |  |          |
| Maryland       | 2 should be and Menta is marked craumatic ev   | ဥ              | John T. Hill  19a. Informant's Name/Relationship                         | (Type Print)   | 19h Mailir             | on Address (Street                       |                               |                            | e Hamil                       | Lton<br>r, City or Town, State | Zin Cada)                                  |          |
|                | and 2 seath ar n 27 is   |                | Darrell T. Hill  | , , ,  | 1                      | 2 Overbro                                |                               |                            |                               |                                | , Zip Code)                                |          |
| altimore,      | es 1 and 2<br>of Health<br>fitem 27 i  |                | 20a. Method of Disposition   | 20b. P   | lace of Dispo          | sition (Name of<br>matory or other place |                               | Dat                        |                               | 20c. Location - City of        | or Town, State                             | -        |
| Ë              | it. Pages<br>intment of l<br>intant: If its<br>injury or o   |                | 1 ☐ Burial 2 ☐ Cremation 3<br>4 ☐ Donation 5 ☐ Other (Spe                |  |                        | ematory                                  |                               | b. 4,                      | 2008                          | Clint                          | on, MD                                     |          |
| a<br>E         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. |                | 21. Signature of Funer Il Service Li                                     | The state of the s |                        | . Name and Addre                         | ss of Facility                | St                         | ewart                         | Funeral Ho                     | ome. Inc.                                  |          |
| <u> </u>       | 8 2 5 6 6  |                | DIMOC  | Daroll de  |                        |  |                               | ad, N                      | IE Wash                       | ington, Do                     | •  |          |
| 1              |  |                | 23a. Part1. Poter the disease, or co<br>shock, or heart failure. List or | emplications that caused the death   | . Do not ent           | er the mode of dyir                      | ng, such as o                 | cardiac or i               | respiratory arre              | est,                           | Approximate<br>Interval Between            | I        |
| 8              | Physician  |                | Immediate Cause (Final disease or condition resulting in death)          | _a Malignant   | Cardia                 | 1 Arryth                                 | mia                           |                            |                               |                                | Onset and Death                            |          |
| 8              | /Medical<br>Examiner   |                | resulting in death)  | Due to (or as a consequ<br>Dementia  |                        | 5.0                                      |                               |                            |                               |                                |  |          |
| -              | /167 <sub>0</sub>  | e.             | Sequentially list conditions,  | b. Due to for as a connecu   | leaves offr            |  |                               |                            |                               |                                |  | _        |
|                | uted<br>d<br>ansit   | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events   | c Prostate C   | ancer                  |  |                               |                            |                               |                                |  |          |
| o o            | an an<br>rial-tr   |                | resulting in death) Last   | Due to (or as a consequ  |                        |  |                               |                            |                               |                                |  |          |
| 8760,          | death certificate be executed<br>e attending physician and<br>of for use as the burial-transit   | ical           |  | d. <u>Diabetes M</u>   | ellitu                 | s  |                               |                            |                               |                                |  |          |
| 9              | eath certifica<br>attending ph<br>for use as t   | Med            | IF FEMALE:   |  |                        |  |                               |                            |                               |                                |  |          |
| Box            | attenc<br>for us   | ian/           | 23b. Was decedent pregnant in the past 12 months?                        | 23c. If yes, outcome pf pregnal  | death 3                | Ectopic pregnancy                        | y                             |                            |                               | 23d. Date of d<br>Month        | elivery<br>Day Year                        | i        |
| Р.<br>О.       | at the de<br>by the a<br>tached  | Physician/Mec  | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 4□Pregnant at time of de<br>9□Unknown  | eatn 5∟                | Other (specify) _                        |                               |                            |                               |                                | ,  |          |
|                | law requires that the<br>as been signed by th<br>2 should be detache   |                | Part II. Other significant conditions                                    | s contributing to death but not resu   | Iting in the ur        | nderlying cause giv                      | en în Part I.                 |                            | 23e. Did tob                  | pacco use contribute           | to the cause of death?                     | $\neg$   |
| rds            | w requires that<br>been signed b<br>should be deta   | ed by          |  |  |                        |  |                               |                            | 1 □ Y∈                        | es 2□No 3□I                    | Probably 4 Unknown                         |          |
| ပ္က            | aw re  | olete          |  |  |                        |  |                               |                            | 24a. Was ai                   |                                | autopsy findings available                 | $\neg$   |
| ř              | The hard   | Completed      |  |  |                        |  |                               |                            | autops<br>perform<br>1□ Yes 2 | ned? death?                    | o completion of cause of<br>?<br>es 2 □ No |          |
| Vital Records, | sician; The law<br>certificate has b<br>irector, page 2 s  | Be             | 25. Was case referred to medical examiner?                               |  |                        |  |                               | of Death                   | Check onl on                  | el _                           | enior Assiste                              |          |
| or o           | Physic<br>this c   | P              | 1 ☐ Yes 2X No  |  | R/Outpatien            |  | 4 🗆 1901:                     | sing Home                  | 5 🗆 Reside                    | ence 6 Other (Sp               | ecify) Living                              | _        |
| ח              | ding I   | io<br>ii       | 27. Manner of Death  1 X Natural 5 □ Pending                             | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of<br>Injury | Wor                                      | y at<br>k?                    | 286                        | d. Describe ho                | w injury occurred              | O  |          |
| Division       | death<br>death<br>ctor:<br>y the   | licat          | 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not                        | be 290 Blace of injury. At hos   | me. farm. stre         |  | Yes 2 □ N                     |                            | Location (St                  | reet and Number or I           | Pural Route Number                         | -        |
| S              | al or /  | Certification: | 4 ☐ Homicide determine   | building, etc. (Specify  |                        | •  |                               |                            | City or Town                  | i, State)                      | Tara Troute (Tarribor,                     |          |
|                | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.   | ial C          | 29a. Certifier (Check only 2 Medical Ex                                  | Physician: To the best of my know  | vledge, death          | occurred at the tir                      | me, date and                  | place, an                  | d due to the ca               | ause(s) and manner             | as stated.                                 | 7        |
|                | the H<br>iin 24<br>the Fi  | ledical        | one)   | aminer: On the basis of examinati<br>and manner stated.  | on and/or inv          |  |                               | n occurred                 | at the time, di               | ate and place, and di          | ue to the cause(s)                         |          |
|                | To Con   | Σ              | 29b. Signature and title of certifier                                    | )/_  |                        | 29c. Licens                              |                               |                            | 29                            | 9d. Date signed (Mo            | nth, Day, Year)                            |          |
| 1              | 8  |                |  |  |                        | D581                                     | 182                           |                            |                               | January :                      | 30, 2008                                   |          |
| K              | 10)  |                | 30. Name and address of person where C. Donald Geor                      |  |                        |  | <sub>7</sub> #1Ω1             | A Gra                      | enhel+                        | , MD 2077                      | n  |          |
|                | Sta  | e              | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signat   |                        | Laraway                                  | , ,, 101.                     | 016                        | CHUCTL                        | , 110 2011                     |  | $\dashv$ |
|                | Registra   | _              | FEB 0 1 2008   | Krow & A   | recte                  |  |                               |                            |                               |                                |  |          |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Year Mary Alice Kirby Druary 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X F Director 219-46-3286 61 Dec.23,1946 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show at XXYes 2 □ No Director Washington permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If them 27 is marked other than "many injury or other traumation." Maryland Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 West Frederick St. 21795 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2XXVIo If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Dietician Manager Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Nellie Pearl Forsythe Paul Eugene Lowman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth E. Kirby, Sr.-Husband 29 W. Frederick St. Williamsport, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State MXBurial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) Greenlawn Mem. Park Feb.5,2008 Williamsport, Maryland 21 Signature of Funer Service Ocen ee USDOPRE FURSTERINGHOME. P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a, art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** HYPOXIC ENCEPHALOPATH /Medical Due to (or as a consequence of): Examiner CAMPIAZ ARRYTHMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence or, The law requires that the death certificate be executed RESPIRATORT FAILURE burial-trar Due to (or as a consequence of): P.O. Box 68760, RENA FAILURG the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, sign. be c Completed by CORONART ARTERT DISEMSE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown SEIZURE DIABETES 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perforn 2 No 1□ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical

05H-9 State

31. Date filed (Month, Day, Year) FEB 0 5 2008

29b. Signature and title of certifier

DINID



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

D0862006

29d. Date signed (Month, Day, Year)

0

HAUGRITOUN

2008

|  |                            | For<br>State<br>Registrar                                 |                                   | State of   | Marylar                       | nd / Depa                        |                                  | of Hea                  | Ith and M                   | fental Hy                       |            | 0000   |                                  | 3 4 1             |
|--|----------------------------|---|-----------------------------------|--|-------------------------------|----------------------------------|----------------------------------|-------------------------|-----------------------------|---------------------------------|------------|--|----------------------------------|-------------------|
| 55 1   |                            | 1. Decedent's Name (Fi                                    | irst, Middle, La                  | st)  |                               |                                  |                                  |                         |                             | 2. Date of De                   | eath       |  | 3. Time of D                     | Death             |
| Phys   | cian<br>dical              | Mark  | Chri                              | stopher  | Ker                           | nedy                             |                                  |                         |                             | Month<br>Janua                  | Day        | 9, 2008  | 11:00a                           | М                 |
| Exan   |                            | 4a. Facility Name (If not                                 |                                   |  |                               |                                  | 4b. City, Tox                    | wn, or Loca             | ation of Death              |                                 |            | County of Deat                                   |                                  |                   |
|  |                            | 300 Water   | ford R                            | hac  |                               |                                  | Si-                              | lvor                    | Spring                      |                                 |            | Mond   |                                  |                   |
| Funer  | al                         | 5. Social Security Numb                                   | er 6. S                           | Sex  | 7. Age (In yrs.               | last birthday)                   | If Under 1 \                     | ear If L                | Jnder 24 Hrs.               | 8. Date of Bi                   | rth        | 9. Birtl   | tgomery  place (State or         | Foreign           |
| Directo  | •                          | 579-62-37   | 92                                | XXM 2□F  | 60                            | Yrs.                             | Months D                         | ays Ho                  | ours Min.                   | (Month, D                       |            |  | uintry)<br>nington,              | DC                |
| 72   |                            | Usual Residence of Dec                                    | cedent                            |  |                               |                                  |                                  |                         |                             | Aug. I                          | Up 15      | 47 Masi  | my com,                          | DC                |
| trylar<br>show   | 3m                         | 10a. State 10   | b. County                         |  | 10c. Cit                      | ty, Town or Lo                   | cation                           |                         |                             |                                 |            |  | 10d. Inside City                 |                   |
| e Ma<br>Sa-f s   | 양                          | Maryland  | Mor                               | ntgomery   |                               | Silve                            | r Sprin                          | nα                      |                             |                                 |            |  | 1 ☐ Yes                          | <sup>2</sup> ▼ No |
| 1036<br>purs after death with the Marylar<br>ral", or items 23a or 28a-f show<br>Examiner must be notified at  | Director                   | 10e. Street and Number                                    | r                                 | 5 3  |                               |                                  | 10f. Zip Co                      | ode                     |                             |                                 | 10g. Citiz | en of What Co                                    | untry?                           |                   |
| ath w<br>23a<br>ust b  | 2                          | 300 Wate  | rford 1                           | Road   |                               |                                  |                                  | 20                      | 901                         |                                 | U          | ISA  |                                  |                   |
| r dek  | Funeral                    | 11. Marital Status  |                                   | 12. Was Dece                                       | ces?                          | .S. 13.1                         | Was Deceden                      | t of Hispan<br>Cuban, M | nic Origin? (Specification) | ecify Yes or No<br>Rican, etc.) | 0- 1       | <ol> <li>Race - Amer<br/>Black, White</li> </ol> |                                  |                   |
| 36 afte  | F                          | 1 Never Married   |                                   | 1.□Yes<br>HYes, Give                               | 2 □ No<br>e                   |                                  | 1 ☐ Yes 2 ☐                      | -                       | ecity:                      | , , , , , , , ,                 |            |  | Vhite                            |                   |
| DOC<br>DOURS   | d by                       | 3 ☐ Widowed 4 ☐   |                                   | Year or Da   | tes:Vietn                     |                                  |                                  |                         |                             |                                 |            | ореспу.  |                                  |                   |
| 21215-0<br>d within 72 ho<br>giene.<br>r than "natu  | Completed                  | 15.<br>(Specify o   | Decedent's Ed<br>only highest gra | ducation<br>ade completed)                         |                               | (Give                            | dent's Usual C<br>kind of work o | done durino             | g most of work              | ing                             | 16b. Kin   | d of Business/I                                  | ndustry                          |                   |
| 121<br>vithin  | E G                        | Elementary/Secondar                                       | y (0-12)                          | College (1-  | 4or 5+)                       | life. I                          | DO <b>NO</b> T use r             | retired)                |                             | _                               |            |  |                                  |                   |
| d 21215-0036<br>filed within 72 hours after death with the Maryland<br>Hygiene.<br>wher than "natural", or items 23a or 28a-f show<br>ent, the Medical Examiner must be notified at  |                            | 17. Father's Name (Firs                                   | t Middle Leet                     | 4  |                               | Mo                               | otor Me                          |                         |                             | /Fi 1 # 1 H                     | Aut        | omobile  | Repair                           |                   |
| e d ala  | Be                         | John Roye   |                                   |  |                               |                                  |                                  | 18.1                    |                             | e (First, Middle<br>ary Mar     |            | ,  |                                  |                   |
| aryland 212<br>should be filed withind Mental Hygiene.   | 은                          | ·   |                                   |  |                               | 1                                |                                  |                         |                             |                                 |            |  |                                  |                   |
| (C) 00 = 10 =  |                            | 19a. Informant's Name                                     |                                   |  |                               |                                  |                                  |                         |                             |                                 |            | Town, State, Z                                   |                                  |                   |
| C - 14 L   |                            | Colleen A.  |                                   | dy/Wife  | look r                        |                                  |                                  |                         |                             |                                 |            | g, MD 2  |                                  |                   |
| Orc<br>ges t<br>t of H<br>if ite<br>or ot  |                            | 20a. Method of Dispositi<br>1 ☐ Burial 2 💆 Cr             |                                   | Removal from S                                     |                               | Place of Dispo<br>cemetery, crer | sition (Name on atory or other   | of<br>r place)          | Jan.                        | <sup>Jate</sup> 30              | 20c. Loc   | ation - City or 1                                | Fown, State                      |                   |
| Baltimore, permit. Pages 1 a Department of Hee Important: If item any injury or othe   |                            | 4 Donation 5 □  |                                   |  | Me                            |                                  | itan Cr                          |                         | OLY                         | 800                             | Ale        | xandria  | ,_Virgi                          | nia               |
| Sall<br>ermit<br>epar<br>npor<br>ny in   | 5                          | 21. Signature Funera                                      | I Service Licer                   | nsee /   | 0                             | Fi                               | Name and A                       | ddress of               | Facility<br>OIIins          | Funera                          | 1 Hom      | e Inc.   |                                  |                   |
| m 505 a  |                            |   | when                              | ) <del>\</del> \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | , le                          | 50                               | 00 Univ                          | ersi                    | ty Blyd                     | , W.,                           | Silve      |  | a, MD 2                          | 0901              |
|  |                            | 23a. Part1. Enter the di<br>shock, or heart fai           | sease, or com<br>lure. List only  | plications that ca<br>one cause on ea              | used the deat<br>ch line.     | h. Do not ent                    | er the mode o                    | f dying, su             | ch as cardiac               | or respiratory a                | arrest,    |  | Approximate<br>Interval Betw     | een               |
| Physicia   | 1 1                        | Immediate Cause (Fina disease or condition                | I                                 | . Metas  | tatic D                       | Melanor                          | na to S                          | :k1111                  | .Taw                        |                                 |            |  | Onset and De                     | ∌ath              |
| /Medica  |                            | resulting in death)                                       |                                   |  | or as a conseq                |                                  |                                  | MULL                    | Juan                        |                                 |            |  |                                  |                   |
| Examine  | S                          | Sequentially list condition                               | one                               | b  |                               |                                  |                                  |                         |                             |                                 |            |  |                                  |                   |
| A 9 =  | ne                         | Sequentially list condition if any, leading to immediate. | ilate                             |  | r as a conseq                 | uence of):                       |                                  |                         |                             |                                 |            |  |                                  |                   |
| 760, te be executed ysician and burial-transit   | Examiner                   | that initiated events                                     | y T                               | C  |                               |                                  |                                  |                         |                             |                                 |            |  |                                  |                   |
| 760, te be exe   |                            | resulting in death) Last                                  | - 1                               | Due to (a  | or as a conseq                | uence of):                       |                                  |                         |                             |                                 |            |  |                                  |                   |
| e ys   | ical                       |   |                                   | _d   |                               |                                  |                                  |                         |                             |                                 |            |  |                                  |                   |
| Vision or Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certifical death.  death. ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the  | Completed by Physician/Med | IE ECMALE.  |                                   |  |                               |                                  |                                  |                         |                             |                                 |            |  |                                  |                   |
| th ce  | an/                        | IF FEMALE:<br>23b. Was decedent pre-                      | gnant                             | 23c. If yes, outo                                  | ome pf pregna<br>rth 2 □ Feta |                                  | Ectopic pregr                    | ancv                    |                             |                                 | 23         | 3d. Date of deliv                                | very                             |                   |
| dea  | iż.                        | in the past 12 mon<br>1 ☐ Yes 2 ☐ No                      | ths?                              |  | int at time of d              |                                  | Other (specif                    |                         |                             |                                 |            | Month  | Day Ye                           | ear               |
| P.O nat the d by the etache  | ly,                        | 9 □ Unknown   |                                   |  |                               |                                  |                                  |                         |                             |                                 |            |  |                                  |                   |
| cords, P.O. Box w requires that the death cer been signed by the attendin should be detached for use   | J. F                       | Part II. Other significan                                 | t conditions o                    | ontributing to dea                                 | ath but not res               | ulting in the ur                 | nderlying caus                   | e given in I            | Part I.                     | 23e. Did 1                      | tobacco us | e contribute to                                  | the cause of de                  | ath?              |
| Division or Vital Records, or Attending Physician: The law requires that death.  Director: After this certificate has been signe in by the funeral director, page 2 should be come.  | pa                         | Metastatic  | Prosta                            | te Canc  | er to I                       | Bones_                           |                                  |                         |                             | 1 🗆                             | Yes 2      | No 3□ Pro  | bably 4 🛣 Ur                     | ıknown            |
| aw re  | Set                        |   |                                   |  |                               |                                  |                                  |                         |                             | 24a. Was                        | an         | 24b. Were aut                                    | opsy findings av                 | /ailable          |
| Rec<br>The lav<br>te has<br>age 2  | E                          | -   |                                   |  |                               |                                  |                                  |                         |                             |                                 | ormed?     | death?   | opsy findings avompletion of cau | ise of            |
| an: an:  | Ö                          | 25. Was case referred to                                  | o medical                         |  |                               |                                  |                                  | 26                      | Plana of Death              | 1 ☐ Yes                         |            | 1 ☐ Yes  | 2∐ No                            |                   |
| /sick  | To Be                      | examiner?<br>1 ☐ Yes 2 ☑ No                               | 11                                | Hospital:  | patient 2                     | ER/Outnation                     | + 3□ DOA                         | Odlessi                 |                             |                                 |            | ☐Other (Spec                                     |                                  |                   |
| g Phy<br>g Phy<br>er thi   | Ë                          | 27. Manner of Death                                       | - 7277                            | 28a. Date of<br>(Month                             |                               | 28b. Time of                     |                                  | Injury at<br>Work?      |                             | 28d. Describe                   |            |  | іту)                             |                   |
| ion<br>Iding<br>th.<br>Afte  | 흝                          | 1 🙀 Natural 5<br>2 □ Accident                             | ☐ Pending<br>investigation        |  | , Day Year)                   | Injury                           | М                                | Work?<br>1 ☐ Yes        |                             |                                 | ,,         |  |                                  |                   |
| /iSi   | fica                       | 3 ☐ Suicide 6   | Could not be determined           | 28e. Place c                                       | of injury - At ho             | ome, farm, stre                  | eet, factory, of                 | fice                    | - :                         | 28f. Location (                 | Street and | Number or Rui                                    | al Route Numb                    | er.               |
| Diversity of the property of t | Certification:             | 4  Homicide   | dotominod                         | building   | g, etc. (Specify              | y)                               | •                                |                         |                             | City or To                      | wn, State) | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,          |                                  | J.,               |
| Division or Vital Rewithin 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, and the suppose the completely filled in by the funeral director, page  | S                          | 29a. Certifier 1X   | Certifying Ph                     | ysician: To the b                                  | est of my kno                 | wledge, death                    | occurred at t                    | he time, da             | ate and place.              | and due to the                  | cause(s) a | and manner as                                    | stated                           | 15.               |
| e Ho<br>124 h<br>e Fur<br>fetely   | Medical                    | (Check only 2 one)  | Medical Exan                      | niner: On the bas<br>and manne                     | sis of examina                | tion and/or inv                  | estigation, în                   | my opinior              | n, death occurr             | ed at the time,                 | , date and | place, and due                                   | to the cause(s)                  |                   |
| roth<br>vithin<br>omp  | Me                         | 29b. Signature and title                                  | of certifier (                    | 10   |                               |                                  | 29c. Lie                         | cense num               | nber                        |                                 | 29d. Date  | signed (Month                                    | , Day, Year)                     |                   |
| - > - 0  |                            | ▶ Kabe  | ナルス                               | Tuais  | mr                            | )                                |                                  | D555                    | 522                         |                                 |            |  | 30, 200                          | 8                 |
| 1150   |                            | 30. Name and address of                                   |                                   | ompleted   | of death (the                 | ) 22a\ (T                        | Print)                           | _                       |                             |                                 |            |  | -                                |                   |
| 10.  |                            | Robert H. (   |                                   |  | ,                             | , , , , ,                        | *                                | W. D.                   | n. GR-1                     | O Magi                          | inc+       | on, DC   | 20010                            |                   |
| 9  | tate                       | 31. Date filed (Month, Da                                 |                                   |  |                               |                                  |                                  | ., MI                   | GD-1                        | o, wasi                         | iiig t     | oir, DC  | 20010                            |                   |
| Regis  |                            |   | 3 1 20                            | 008  | gistrar's Signa               | is do                            | ale)                             |                         |                             |                                 |            |  |                                  |                   |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|          |  |                | For State of Maryland / State Registrar  |                       | rtment of H<br>tificate of D                             |                                |                                      | ene 2 0                | 08                                    | 04342   |  |  |
|----------|--|----------------|--|-----------------------|--|--------------------------------|--------------------------------------|------------------------|---------------------------------------|---|--|--|
| r        |  |                | Decedent's Name (First, Middle, Last)  |                       |  |                                | 2. Date of Death                     |                        |                                       | 3. Time of Death                              |  |  |
|          | Physicia<br>/Medic   |                | Helen Rebecca Long   |                       |  |                                | Month<br>February                    | Day 1, 20              | Year<br>008                           | 11:20 P <sub>M</sub>                          |  |  |
|          | Examin   |                | 4a. Facility Name (If not institution, give street and number)   |                       | 4b. City, Town, or                                       | Location of Death              |                                      | 4c. County             |                                       |   |  |  |
|          |  |                | 40900 Oakville Road  |                       | Mechani  |                                |                                      |                        |                                       | ary's   |  |  |
|          | Funeral  |                | 5. Social Security Number 219-12-3149 6. Sex 1 □ M 2 점 F 84  | t birthday) _<br>Yrs. | If Under 1 Year<br>Months Days                           | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day, )   |                        | Cour                                  |   |  |  |
|          | Director   |                | Usual Residence of Decedent  |                       |  |                                | January 21                           | .,1924                 | Mar                                   | yland   |  |  |
|          | yland<br>how<br>at   |                | 10a. State 10b. County 10c. City, To   | own or Loc            | cation   |                                |                                      |                        |                                       | 10d. Inside City Limits                       |  |  |
|          | e Mai<br>la-f si<br>tified   | ctor           | Maryland St. Mary's  |                       | Mech   | anicsvil                       | 1e                                   |                        |                                       | 1 ☐ Yes 22 ☐ No                               |  |  |
|          | or 28  | Director       | 10e. Street and Number   |                       | 10f. Zip Code  |                                | 100                                  | g. Citizen of          |                                       | ntry?   |  |  |
|          | s 23a  | eral           | 40900 Oakville Road  11 Marital Status 12. Was Decedent Ever in U.S.   | 10 14                 |  | 20659                          | noify Van or No                      |                        | JSA                                   | can Indian,                                   |  |  |
| ٥        | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23a or 28a-f show<br>he Medical Examiner must be notified at   | Funeral        | Armed Forces?  1 ☐ Never Married 2 ☐ Married  1 ☐ Yes 2 ☒ No  1 ☐ Yes Give   |                       | Vas Decedent of Hi<br>f Yes, specify Cuba<br>□ Yes 2☑ No | n, Mexican, Puerto             | Rican, etc.)                         |                        | ck, White,                            | etc.  |  |  |
| 5-0036   | hours<br>tural";   | ed by          | 3 ™ Widowed 4 □ Divorced Year or Dates:  | 16a. Deced            | ent's Usual Occupa                                       | ation                          | 10                                   | 6b. Kind of B          | · · · · · · · · · · · · · · · · · · · |   |  |  |
| 5        | in 72<br>In "na<br>Medic   | Completed      | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)   |                       | kind of work done o<br>OO NOT use retired,               | luring most of work<br>)       | ring                                 |                        |                                       |   |  |  |
| 7        | ed with  | Som            | 12   | H                     | lomemaker  |                                |                                      |                        | Own 1                                 | Home  |  |  |
| yland    | be filk<br>d oth<br>event  | Be             | 17. Father's Name (First, Middle, Last)  |                       |  |                                | e (First, Middle, Ma                 |                        | •                                     |   |  |  |
| Ž        | ould Men<br>narke  | ٩              | Edward Newton Lee, Sr.   | 401- 14-11-           | g Address (Street a                                      |                                | rtle Mar                             |                        |                                       | . 0 . (1)                                     |  |  |
| Z        | d 2 sl<br>th an<br>17 is r<br>traur  |                |  |                       | Three No   |                                |                                      |                        |                                       |   |  |  |
| ď        | s 1 an<br>f Heal<br>tem 2<br>other   |                | 20a Method of Disposition 20b. Place   | e of Dispos           | sition (Name of natory or other place                    | 1                              | Date 20                              | Oc. Location           | -                                     |   |  |  |
| gaitimor | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |                |  | Zion                  | Cemetery   | 200                            | uary 5,<br>8                         | echani                 | csvi                                  | lle,Maryland                                  |  |  |
| Dall     | permit. Depart Import any inj  |                | 21. Signartine of Funeral Service Licensee   |                       | Mattingley P.O. Box 2                                    | -Gardiner F                    | uneral Home                          | P.A.                   |                                       |   |  |  |
| F        | 11.  |                | 23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.  | Do not ente           | er the mode of dying                                     |                                |                                      |                        |                                       | Approximate<br>Interval Between               |  |  |
|          | Physician  |                | Immediate Cause (Final disease or condition  | To .                  | TURNE  |                                |                                      |                        |                                       | Onset and Death                               |  |  |
|          | /Medical Examiner  |                | resulting in death)  Due to (or as a consequen   |                       | YEary  |                                |                                      |                        |                                       |   |  |  |
|          | Lxammer  | <u></u>        | ATHEROSCIGNATIC CARDOVASCULAR DIEGIE. YE   |                       |  |                                |                                      |                        |                                       |   |  |  |
|          | uted<br>I<br>Insit   | Examine        | Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):   |                       |  |                                |                                      |                        |                                       |   |  |  |
| <u>_</u> | exection and rial-tra  |                |  |                       |  |                                |                                      |                        |                                       |   |  |  |
| 8/00,    | icate be executed<br>physician and<br>s the burial-transit   | dical          | d  |                       |  |                                |                                      |                        |                                       |   |  |  |
| D        |  | Med            | IF FEMALE:   |                       |  |                                |                                      | L                      | 1                                     |   |  |  |
| X<br>Q   | w requires that the death certif<br>been signed by the attending<br>should be detached for use as  | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?  | eath 3                | Ectopic pregnancy Other (specify)                        |                                |                                      |                        | ate of deliv<br>onth                  | ery<br>Day Year                               |  |  |
| j.       | the de   | ysic           | 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death<br>9 ☐ Unknown 9 ☐ Unknown  | ii 5_                 | Other (speary)   |                                |                                      |                        |                                       |   |  |  |
| 7        | requires that the<br>een signed by th<br>nould be detache  | by Pł          | Part II. Other significant conditions contributing to death but not resulting  | ng in the un          | nderlying cause give                                     | en in Part I.                  | 23e. Did toba                        | acco use con           | tribute to t                          | he cause of death?                            |  |  |
|          | quire<br>en sig<br>uld be  | q pe           | ROVAL TAIL VINE  |                       |  |                                | 1 ☐ Yes                              | 2 No                   | 3 🗌 Prol                              | bably 4 □Unknown                              |  |  |
| ecords,  | law re<br>las bee  | Completed      |  |                       |  |                                | 24a. Was an<br>autopsy               |                        | prior to co                           | opsy findings available ompletion of cause of |  |  |
| Ť        | : The cate h   | Con            |  |                       |  |                                | perform<br>1□ Yes 2                  |                        | death?<br>1 ☐ Yes                     | 2 □ No  |  |  |
| vital    | sician<br>certifi<br>rector  | Be             | 25. Was case referred to medical examiner?  Hospital: 4 Theoretical and the control of the contr |                       | Othe   |                                | h (Check only one                    |                        |                                       |   |  |  |
| ō        | Phys<br>r this<br>ral di   | . To           | 27. Manner of Death 28a. Date of Injury 28   | Bb. Time of           | t 3 DOA Office   | 4 ∐ Nursing Ho                 | ome Residen                          |                        |                                       | (y)   |  |  |
| 0        | nding<br>th.<br>r: Afte<br>e fune  | ıtion          | 1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation   | Injury                |  | t?<br>Yes 2 ☐ No               |                                      |                        |                                       |   |  |  |
| UNISION  | r Atte<br>er dea<br>irecto   | Certification: | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home building, etc. (Specify)   | e, farm, stre         | eet, factory, office                                     |                                | 28f. Location (Stre<br>City or Town, | eet and Num.<br>State) | ber or Run                            | al Route Number,                              |  |  |
| 5        | urs aft<br>ral Di  |                | 2  |                       |  |                                |                                      |                        |                                       |   |  |  |
|          | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s   | Medical        | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowle 2   |                       |  |                                |                                      |                        |                                       |   |  |  |
|          | To th<br>within<br>To th   | Me             | 29b. Signature and title of certifier  | 15                    | 29c. License   |                                |                                      | d. Date signe          |                                       |   |  |  |
|          | (M)  |                | > LUU M  | (D                    | 18   | ,096                           |                                      | 2-4                    | 1-08                                  | •   |  |  |
|          | John John John John John John John John  |                | 30. Name and address of person who completed cause of death (Item 23   | MP                    | Print) 811A  | H ASTO                         | CIATES                               | hore                   | ywo                                   | D. MD 2883                                    |  |  |
|          | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)  See 32. Registrar's Signature  FEB 0 5 2008   | е .                   | (all)  |                                |                                      |                        |                                       |   |  |  |
|          | 3.91   |                | FEB U O ZUUY   | 0"                    |  |                                |                                      |                        |                                       |   |  |  |

Division or Vital Records, P.O. Box 68760

altimore, Maryland 21215-0036

ospital or Attending Physiclan: Thours after death.

Ineral Director: After this certificate filled in by the funeral director, pa To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45880 01/29/2008 30. Name and add ress of person who completed cause of death (Item 23a) (Type, Print) Leon C. Hwang MD 1396 Piccard Dr. Rockville, MD 20850 31. Date filed (Month, Day, Year, ∰egistrar's Signature State 2008 JAN 31 Registrar

|  |                   | Please 7  | Type or Prin                                      |  |                          |                                      | Ensure A<br>Health and N                    | -                               |                      | _                        |                                    |   |
|--|-------------------|---|---|--|--------------------------|--------------------------------------|---|---------------------------------|----------------------|--------------------------|------------------------------------|---|
|  |                   | 1 - For State Registrar   | State of Ma                                       | arylariu / i                           |                          | rificate of                          |   | -                               | giene<br>Reg. No     | 7000                     | 0434                               | 1 |
| Physici  |                   | 1. Decedent's Name (First, Middle, Last   |   |  |                          |                                      |   | 2. Date of De<br>Month          | Da                   |                          | 3. Time of Death                   | _ |
| /Medi<br>Examir  |                   | 4a. Facility Name (If not institution, give                                     |   |  |                          | 4b. City, Town, o                    | r Location of Death                         | Januar                          |                      | 9 08<br>County of Deatl  | 21:32                              |   |
|  | - j               | Sinai- Hospital e   | of Baltin   | nore.                                  |                          | Baltim                               | lore  |                                 |                      |                          |                                    |   |
| Funeral  |                   | 5. Social Security Number 6. Second 1   | х 7. Ag   | e (In yrs. last bii                    |                          | If Under 1 Year<br>Months Days       | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birt<br>(Month, Da   | y, Year              | Cor                      | nplace (State or Foreign<br>untry) | 1 |
| Director   |                   | 242 70 2836 Usual Residence of Decedent   |   | 69                                     |                          |                                      |   | APR. 21                         | <b>,</b> 1           | 938  WIL                 | SON, NC                            |   |
| arylan<br>show<br>d at   | Ë                 | 10a. State 10b. County  |   | 10c. City, Tow                         | n or Loca                | ation                                |   |                                 |                      |                          | 10d. Inside City Limits            |   |
| be filed within 72 hours after death with the Maryland tal Hygjene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at   | Director          | MD<br>10e. Street and Number  |   | BALTI                                  | MORE                     | 10f. Zip Code                        |   |                                 | 10a Cit              | izen of What Cou         | ¶XXYes 2 □ No                      | _ |
| h with   | io le             | 5355 GIST AVENUE  |   |  |                          | 2121                                 | 5   |                                 |                      | TED STA                  |                                    |   |
| ems 2  | Funeral           |   | 12. Was Decedent I<br>Armed Forces?               | Ever in U.S.                           | 13. W                    |                                      | lispanic Origin? (Sp<br>an, Mexican, Puerto | ecify Yes or No                 |                      | 14. Race - Amer          | ican Indian,                       | _ |
| s afte   | by FL             | XX Never Married 2 Married 3 Widowed 4 Divorced                                 | 1 ☐ Yes ② XXIII<br>If Yes, Give<br>Year or Dates: | No                                     |                          | ⊐Yes <b>X</b> (X)No                  | Specify:                                    | Triodii, Glo.)                  |                      | Black, White Specify: BI | ACK                                |   |
| 2 hour   |                   | 15. Decedent's Edu  | cation  | 16a                                    | . Decede                 | nt's Usual Occup                     | nation                                      |                                 | 16b. K               | ind of Business/I        |                                    |   |
| thin 7;<br>ie.<br>ian "n   | Completed         | (Specify only highest grade Elementary/Secondary (0-12)                         | e completed) College (1-4or 5                     | i+)                                    | (Give ki<br>life. DC     | nd of work done<br>O NOT use retired | during most of work<br>d)                   | ting                            |                      |                          | ,                                  |   |
| iled wi<br>dygier<br>her th  |                   | 8TH  17. Father's Name (First, Middle, Last)                                    |   |  | CUS                      | TODIAN                               | 40 Maltanta la Nasa                         | - (5' - 1 1 1 1 1 1             |                      | ITY OF I                 | NEW YORK                           | _ |
| d be fental liked of   | To Be             | DANIEL MERCER   |   |  |                          |                                      | 18. Mother's Nam                            | e (First, Middle,<br>ETH JOR)   |                      | Surname)                 |                                    |   |
| 2 should<br>and Mer<br>is marke<br>aumatic   | F                 | 19a. Informant's Name/Relationship (Ty  | pe. Print)  | 19b                                    | o. Mailing               | Address (Street                      | and Number or Rui                           |                                 |                      | or Town, State, Z        | ip Code)                           | _ |
| and 2<br>ealth a<br>m 27 i   |                   | RENEE MERCER BOYD   | / SISTER  |  |                          | IST AVE                              |   | LTIMORE                         | , MD                 | 21215                    |                                    |   |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |                   | 20a. Method of Disposition  XXBurial 2 □Cremation 3 □F                          | lemoval from State                                | 20b. Place of<br>cemete                | f Disposit<br>ery, crema | tion (Name of<br>atory or other plac | ce)   | Date                            | 20c. Lo              | ocation - City or T      | own, State                         |   |
| artmer<br>ortant<br>injury   |                   | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License      | ee.   | HAMILT                                 | ON B                     | URIAL GA                             | AR. 02/0                                    | 2/2008                          | WI                   | LSON, NO                 | <u> </u>                           | _ |
| permit. Departimport any inj   |                   | MYK.GX  | D. GRAY   | 4                                      | MA<br>43                 | RSHALL'S                             | ss of Facility S FUNERAL LAND ROAD          | HOME OF                         | F MA                 | RYLAND,<br>, MD 207      | INC.                               |   |
|  |                   | 23a. Part. Phter the disease, or comparished it, or heart failure. List only or | ications that caused<br>ne cause on each lin      | the death. Do                          |                          |                                      |   | or respiratory ar               | rest,                | , IID 201                | Approximate<br>Interval Between    | _ |
| Physician  |                   | Immediate Cause (Final disease or condition resulting in death)                 | Pnei  | ımoni.                                 | a.                       |                                      |   |                                 |                      |                          | Onset and Death                    |   |
| /Medical<br>Examiner   |                   | resenting in death)   | Due to (or as a                                   | a consequence                          | ,                        | 0011                                 |   |                                 |                      |                          |                                    |   |
|  | Jer               | Sequentially list conditions, if any leganse. Enter Underlying                  | Due to (or as a                                   | a conse uence                          |                          | 04 < 1                               |   |                                 | -                    |                          |                                    |   |
| be executed ician and burial-transit   | Examiner          | Cause (Disease or injury that initiated events resulting in death) Last         |   |  |                          |                                      |   |                                 |                      |                          |                                    |   |
| be exician a   |                   |   |   | a consequence                          | of):                     |                                      |   |                                 |                      |                          |                                    |   |
| The law requires that the death certificate to the lass been signed by the attending physic bage 2 should be detached for use as the base.   | Physician/Medical |   |   |  |                          |                                      |   |                                 |                      |                          |                                    |   |
| th cert<br>tendin<br>r use   | an/M              | 23b. Was decedent pregnant  | 3c. If yes, outcome p                             |  | . 3∏E                    | ctopic pregnancy                     | ,   |                                 |                      | 23d. Date of deliv       | very                               |   |
| he des<br>the at<br>thed fo  | /sici             | in the past 12 months?<br>1 □ Yes XX No<br>9 □ Unknown                          | 4□Pregnant at<br>9□Unknown                        |  |                          | Other (specify)                      |   |                                 |                      | Month                    | Day Year                           |   |
| w requires that the d<br>been signed by the<br>should be detached  |                   | Part II. Other significant conditions cor                                       | ntributing to death bu                            | ıt not resulting ir                    | n the und                | erlying cause give                   | en in Part I.                               | 23e. Did to                     | bacco ı              | ise contribute to        | the cause of death?                |   |
| quires<br>en sigr  | Completed by      | 9CVA, Mypt  | ococcal   | Lun.                                   | 900                      | nia,                                 |   | 1 🗆 Y                           | es 2                 | □ No 3 □ Pro             | bably 4 Unknown                    |   |
| e law re<br>has bee  | plet              | Anemia  |   |  |                          |                                      |   | 24a. Was a                      |                      | 24b. Were aut            | opsy findings available            | _ |
|  | Com               |   |   |  |                          |                                      |   | perfor                          |                      | death?                   | ompletion of cause of<br>2⊠No      |   |
| siclan: Th<br>certificate<br>irector, pag  | Be                | 25. Was case referred to medical examiner?                                      | lospital:   |  |                          | 2 DOA Othe                           | 26. Place of Death                          |                                 |                      |                          |                                    |   |
| g Phy<br>er this<br>eral di  | ۳: T              | 1 ☐ Yes 2 ☒ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐                              | 28a. Date of Injur                                | y 28b. 7                               | Time of                  | 28c. Injury                          | 4 LI Nursing Ho                             | me 5 Resid                      |                      | 6 □Other (Speci          | ify)                               |   |
| endin<br>eath.<br>or; Aff  | atio              | 1 Natural 5 Pending investigation   | (Month, Day                                       | rear) II                               | njury                    |                                      | Yes 2□No                                    |                                 |                      |                          |                                    |   |
| or Att   | Certification:    | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined                         | 28e. Place of inju<br>building, etc               | ry - At home, fa<br>. <i>(Specify)</i> | rm, stree                | t, factory, office                   |   | 28f. Location (S<br>City or Tow | treet an<br>n, State | d Number or Run<br>)     | al Route Number,                   |   |
| spital   |                   | 29a. Certifier 12 Certifying Phys   | ician: To the best o                              | f my knowledge                         | e, death o               | ccurred at the tin                   | ne, date and place                          | and due to the                  | ause(s)              | and manner as            | stated                             |   |
| To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, it   | Medical           | (Check only 2 Medical Examin  | ner: On the basis of and manner sta               | examination an                         | d/or inve                | stigation, in my o                   | pinion, death occur                         | red at the time,                | date and             | place, and due           | to the cause(s)                    |   |
| To t<br>To t   | Σ                 | 29b. Signature and title of certifier   | 1 20  | h                                      |                          | 29c. License                         |   |                                 |                      | e signed (Month)         |                                    |   |
| (3)  | -                 |   | wal M   |  | J Hillian                |                                      | 5 000                                       |                                 | Jane                 | 10xy., 2                 | 9,2008.                            |   |
| DC.  |                   | 30. Name and address of person who do   |   |  |                          |                                      | altimore                                    |                                 |                      |                          |                                    |   |
| Sta  | te                | 31. Date filed (Month, Day, Year) FFB 0 1 2008                                  | 32. Registra                                      | r's Signature                          |                          | <u> </u>                             | .,0.7.7-,                                   |                                 |                      |                          |                                    | _ |
| Registra   |                   | LED A T COOL  | and you   | 19mm                                   |                          |                                      |   |                                 |                      |                          |                                    |   |

| 08- | 1158   |                | Please Type  | or Print in Black Indelible Ir  | ık. Ensur                    | e All Copies                                     | Are Legible  |                      |                                    |
|-----|--|----------------|--|---|------------------------------|--|--|----------------------|------------------------------------|
| Car | oline Wendy  |                | rtin State   | of Maryland / Department of   |                              | d Mental Hyg                                     | iene   | 200                  | 8 0434                             |
|     | Physicia   |                | Registrar  1. Decedent's Name (First, Middle,La                | Certificate of  | Death                        | 2.   | Reg. No. Date of Death   |                      | 3. Time of Death                   |
| Me  | dical Exami  |                | CAROLINE WE  |   |                              | F  | Month Day<br>February 9, 200   | Year<br>8            | 1750 hrs                           |
| ₹.  |  |                | 4a. Facility Name (if not institution, gi                      |   | •                            | Location of Death                                |  | County of Death      |                                    |
| 5   |  |                | 8150 Elizabeth Road  5. Social Security Number 6. S            | Sex 7. Age (In yrs. last birthday)  | Pasadena<br>If Under 1 Yea   | r If Under 24Hrs.                                | 3. Date of Birth(MM/I  | nne Arundel          | place (State or                    |
|     | Funeral<br>Director  |                |  | M 2 F GO Yrs.   | Months Day                   |  | 12-14-47   | Foreign              |                                    |
|     |  |                | Usual Residence of Decedent                                    | M Z V F GC 113.   |                              |  | 121911   |                      | /5(0)                              |
|     | w any  |                | 10a. State 10b. County   | 10c. City, Town or Locati   | on                           | <del></del>                                      | <del></del>  |                      | 10d. Inside City Limits 1 Yes 2 No |
|     | /land<br>-f sho  | tor            | MD ANNE  | HRUNDEL AS  | ADEN                         | +  | 10g Citis  | en of What Count     |                                    |
| -   | e Mar<br>or 28a<br>Ted at  | ral Director   | 10e. Street and Number   | Λ.  | 10f. Zip Code                | 100  | Tog. Citiz   | 1 ) ( . 4            | <b>3</b> •                         |
| 2   | with thes 23a  | ral            | 11. Marital Status   |   |                              | spanic Origin? ( Speci                           |  | 14. Race - Americ    | an Indian, Black,                  |
|     | death r<br>r item  | Funer          | 1 Never Married 2 Marrie                                       | d Armed Forces? If You 1 Yes 2 No   | es, specify Cubar            | n, Mexican, Puerto Rio                           | can, etc.)   | White, etc.          |                                    |
|     | after<br>ral", o   | by F           |  | or Dates:   |                              | specify:   | Acres de la constante de la co | Specify: ()          | 1176                               |
|     | 2 hour<br>"natu  | ted            | 15. Decedent's Education (Specify delementary/Secondary (0-12) | College (1-4 or 5+)   |                              | tion (Give kind of wor<br>. DO NOT use retired   |  | ind or business/in   | ladistry                           |
|     | 036<br>tthin 7<br>ne.  | Completed      | 12   | NURSI   | NA ASS                       | ISTANT   | 1  | LEDIC                | Al                                 |
|     | 5-0<br>iled wi<br>Hygie<br>d other   | S              | 17. Father's Name (First, Middle, Las                          |   | <del></del>                  | 18.Mother's Name (F                              | irst, Middle, Maiden   | Surname) しん          | 4                                  |
|     | imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Fleath and Mental Hygiene.  tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other transmatic event, the Medical Examiner must be notified at once.  | To Be          | 19a. Informant's Name/Relationship (                           | Type, Print ) 19b, Mailing  | Address (Stree               | et and Number or Rur                             | al Route Number. Ci  | ty or Town, State,   | Zip Code)                          |
|     | MD 2 shoulth and 1 is r  | -              | STEVEN MARTIN.   |   | LIZABE                       |  | ADENA, A   |                      |                                    |
|     | Te, I and I healt Healt  |                | 20a. Method of Disposition                                     | 20b. Place of Dispos  | ition (Name of ce            |  |  | _ocation - City or 1 |                                    |
|     | Pages<br>nent of<br>ant: I   |                | 1 Burial 2 Cremation 3 4 Donation 5 Other Specif               | The individual of the state of |                              | ORY 2-1  | 1-08 HA  | NOVER                | MD,                                |
|     | Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  |                | 21. Signature of Funeral Service Lice                          | 22. N   | lame and Address Daugherty F | s of Facility<br>amily Funeral Hon               | ne And Cremation   | Center, P.A.         |                                    |
|     | Physician  |                | 3. Part I. Enter the dis less, or com                          | lications to a sed the death. Do not enter the  | 2601                         | Mountain Road -                                  | Pasadena MD 3  | 21122                | Approximate Interval               |
| 13  | /Medical   |                | failure. List only one cause                                   | Intracerebral hemorrhace  |                              |  |  |                      | Between Onset and<br>Death         |
|     | <sup>-</sup> xaminer   |                | or condition resulting in death)                               | Due to (or as a consequence of):  |                              |  |  |                      |                                    |
|     |  | -              | Sequentially list conditions, if any, leading to immediate     | Due to (or as a consequence of):  |                              |  |  |                      |                                    |
|     |  | xaminer        | reuse Enter Underfulno Ceuss                                   |   |                              |  |  |                      |                                    |
|     | ited<br>J<br>ansit   | ш              | events resulting in death) Last                                | Due to (or as a consequence of):  |                              |  |  |                      |                                    |
|     | execute<br>tan and<br>ial - tran   | sician/Medical | X UNPENDED   | A#5NDED<br>#23a,PII,27,perME,g877 3   | 1/6/08 TT                    |  |  |                      |                                    |
|     | 760,<br>cate be<br>physic  | /Mec           | IF FEMALE:   | 23c. If yes, outcome of pregnancy   |                              |  |  | d. Date of delivery  |                                    |
|     | certificant certif | cian           | 23b. Was decedent pregnant in the past 12 months?              | Downward at time of death   | tal death 3<br>her (Specify) | Ectopic pregnanc                                 | у  | Month D              | ay Year                            |
|     | Box<br>death   | Physi          | 1 Yes 2 No 9 V Unknow  |   | Her (Opcomy)                 | 5-1-1-12-15-15-15-15-15-15-15-15-15-15-15-15-15- |  |                      |                                    |
|     | .O.<br>that the<br>detache   | by PI          |  | contributing to death but not resulting in the L  | underlying cause             | given in Part I.                                 |  | use contribute to t  | the cause of death? ably 4 Unknown |
|     | IS, Figurines and be asign   | ted t          | Hypertension; Obe  | sity; diabetes mellitus   |                              | <del>.</del>                                     | 24a. Was an  |                      | topsy findings available           |
|     | Sord<br>law red<br>has be<br>2 shou  | Completed      |  |   |                              |  | autopsy performed?   |                      | ompletion of cause of              |
|     | Rec<br>: The<br>ficate   | Cou            | 05. W  |   | 26 Place                     | e of Death (Check on                             | 1 Yes 2 N  | o 1 Ye               | s 2 No                             |
|     | /ital  | Be             | 25. Was case referred to medical examiner?                     | Hospital: 1 Inpatient 2 ER/Outpatient   |                              | Other  |  | ence 6 🗸 Other       | : Scene                            |
|     | of \\ ug Phy ug Phy ufter th   | 7: To          | 1 Yes 2 No<br>27. Manner of Death                              | 28a. Date of Injury 28b. Time of I  | njury 28c. Inju              | ry at Work?                                      | 3d. Describe how inju  | ry occurred          |                                    |
|     | ion<br>Itendir<br>Ieath.<br>Itor: A  | atio           | 1 X Natural 5 Pending 2 Accident Investiga                     |   | 1                            | Yes 2 No   |  |                      |                                    |
|     | Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate buts after death.  al Director: After this certificate has been signed by the attending physicited in by the fumeral director, page 2 should be detached for use as the but   | Certification: | 3 Suicide 6 Could no   | ot be 28e. Place of Injury - At home, farm, stree   | et, factory, office I        | building, etc. 28                                | 3f. Location (Street a<br>or Town, State)  | nd Number or Ru      | ral Route Number, City             |
|     | Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit  |                | 4 Homicide determin  | ed (Specify)  cian: To the best of my knowledge, death occur  | rred at the time d           | ate and place, and di                            | ie to the cause/s\ as  | nd manner as state   | ed.                                |
|     | thin 24<br>the F<br>the F  | Medical        | (Check only   Certifying Physi                                 | er: On the basis of examination and/or investigal and manner stated.  | tion, in my opinior          | n, death occurred at t                           | he time, date and pla  | ice, and due to the  | e cause(s)                         |
|     | 5. ≥ 5. §  | Me             | 29b. Signature and title of certifier                          | and mainer state).  | 29c. Licens                  | se number  | 29d.   | Date signed (Mor     | nth, Day, Year)                    |

DHMH 17 Rev 1/2001 OCME 2006

State 31. Date filed (Month, Day, Year) Registrar

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Ling Li, MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License number O.C.M.E.

February 10, 2008

Registrar
DHMH 17 Rev 1/2001

State

Guchuan D

31. Date filed (Month, Da

10 CENTER DRIVE, BETHESDA, MD 20892

10899

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month January 22, LECOUNT **EDWARD** POOLE 12 DD AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Clinton, Maryland Clinton Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8/3/1943 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**□M 2□F Wash, DC Director 579-56-6955 64 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 20616 **X**□Yes 2□No Bryans Road, MD Maryland Director Charles 10e. Street and Number 10f. Zip Code 20616 10g. Citizen of What Country?
United States 2062 Waiden Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 XNo Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Private 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosalie Blanche Roscoe Irving Poole, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2062 Waiden Court, Bryans Road, MD 20616 Lucille Poole (Wife) 20b. Place of Disposition (Name of Cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Adelphi, MD 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/29/2008 Pope Funezal Fallomes, PA 21. Signature of Suneral Service Licensee 5538 Marlboro Pike, Forestville, MD 20747 immons 23a. Part1. Enter the dise shock, or heart failur e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final LRSPranky **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): AMexica Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 9□Unknown Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 20 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 TYes 2 TyNo ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 1X Natural 5 Pending investigation

**Examiner** and use as the bunal-tran Division or Vital Records, P.O. Box 68760, nding physician The law requires that the death certificate be signed by t peen certificate the Hospital or Attending Physician:

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

"natural", or items 23a or 28a-f show edical Ex miner must be notified at

traumatic event, the Medical

and Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event

Certification:

within 24 hours after deam.

To the Funeral Director:

State

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

6 ☐ Could not be

determined

29c. License number

1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year,

FEB 0 1 2008 Registrar

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] [] ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Physician 8:00 P M Lucy Virginia Peake 2008 30, January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Kingshire Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. Director May 16, 1910 97 Maryland 220-38-2593 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show 1 ☐ Yes 2X No Director MD Montgomery Rockville r than "natural", or items 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 USA 9701 Medical Center Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐XNo If Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify. δ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ith and Mental Hygiene. 27 ie marked other than "r r treumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental I Fred M. McGraw Mary Graves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: if item 27 ie
any injury or other treu Cal Davies/son 4800 Powder House Drive Rockville, MD 20853 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 02/01/08 Beltsville, MD 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 The MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician immediate a Respiratory Failure /Medical Due to (or as a consequence of): Examiner 2 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b Pneumonia Due to (or as a consequence of). Examine certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Colon Cancer 1 Yes 2 No 3 Probably 4 Unknown Completed The law Dementia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2\X\No Division of Vital Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 11Ving Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient ۵ 1 Yes 2 No 3□ DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Attending 5 Pending investigation death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after d To the Funerel Direct 4 | Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai (Cneck only one) 2 Medical Examiner: Un the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 31, 2008 D28656 Dayson E.G. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8609 2nd Ave. Suite 404B Silver Spring, MD 20910 Ravi Passi, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 2008

DHMH 17 Rev 1/2001

Registrar

FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January ™28, 2008 **Physician** 3:56 pM Mary Katherine Russell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Allogh, Dayo Year 1918 Wash (State or Foreign Wash (1918) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 □ XF 89 579-01-8030 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified MD Anne Arundel Crofton 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? ms 23a or 2 1518 Farlow Ave. USA Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or items 23s Funeral item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify Completed by 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operator C&P Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Geier Madeline Stone ဥ 19a. Informant's Name/Relationship (Type. Print, Linda Foster (friend) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1518 Farlow Ave. Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Olivet Cemetery Feb. 2,2008 Wash. DC 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature Funeral Service Licenses MICHO 9013 Annapolis Rd. Lanham, md. 20706 reations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each inte Pari 1. Enter the disease, or con hock, or heart fa ure. List Approximate Interval Between Onset and Death mmediate Cause (Fina **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner the death certificate be executed the burial-tran Due to (or as a consequence of) attending physician for use as the buris Physiclan/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 Other (specify) cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 → No Nown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes Z No After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes P No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mayor of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural Injury 5 | Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, The law requires that

altimore, Maryland 21215-0036

30. Name State

Medical

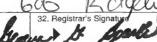
29a. Certifier

(Check only one)

29b. Signature and

10/0 31 Date filed (Month, Day, Year) 1 2008

ine of certifier



d address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

| Division or Vital Records, P.O. Box 68760,   |                        | Baltimore, Maryland 21215-0036   |
|--|------------------------|--|
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.   |                        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hvoiene                                      |
| To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | sicia<br>edica<br>mine | C   C   Important: If item 27 is marked other traumalr, or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at |

Physicia /Medic Examin

Funeral Director

|                                     | 1 - For<br>State<br>Registrar  | State of Ivia   | ylallu                |                                 | ificate of   |                                | iliu ivie                 |  | Reg. No           | 1                    | 008                            | 3 0435  | 6  |
|-------------------------------------|--|---|-----------------------|---------------------------------|--|--------------------------------|---------------------------|--|-------------------|----------------------|--------------------------------|---|----|
| 'n                                  | 1. Decedent's Name (First, Middle, Las   | st)   |                       |                                 |  |                                | 2                         | 2. Date of Dea<br>Month                    | ith<br>Da         | W.                   | Year                           | 3. Time of Death                              |    |
| in<br>al                            | Henry Carl   | Schrader  |                       |                                 |  |                                |                           | Jan 22                                     | 2, 2              | 800                  | Teal                           | 5:36 P M                                      |    |
| er                                  | 4a. Facility Name (If not institution, give  |   |                       | 4                               | lb. City, Town, o                                      | r Location of                  | Death                     |  | 40                | . County             | of Death                       |   |    |
|                                     | NATIONAL NAVAL N   |   |                       |                                 | BETHESI  |                                |                           |  |                   | OMTO                 | OMER                           |   |    |
|                                     | 354-03-0832  | XIM 2DE   | (In yrs. las          |                                 | If Under 1 Year<br>Months Days                         | If Under 24<br>Hours           | Min.                      | B. Date of Birth<br>(Month, Day<br>01/05/1 | , Year            |                      | 9. Birth<br>Cou<br><b>I111</b> | place (State or Foreign<br>ntry)<br>nois      |    |
|                                     | Usual Residence of Decedent  10a. State 10b. County                                |   | 10c. City.            | Town or Loca                    | tion   |                                |                           |  |                   |                      |                                | 10d. Inside City Limits                       | _  |
| ctor                                | MD Montgome  |   |                       | omac                            |  |                                |                           |  |                   |                      |                                | 1 ZXYes 2 □ No                                |    |
| Dire                                | 10e. Street and Number   |   |                       |                                 | 10f. Zip Code  |                                |                           | -  | 10g. Ci           | tizen of V           | Vhat Cou                       | ntry?   |    |
| ra                                  | 10234 Democracy  |   |                       |                                 | 20854  |                                |                           |  |                   | ited                 | Sta                            | tes   |    |
| nne                                 | 11. Marital Status   | 12. Was Decedent Ev<br>Armed Forces?<br>1 XYes 2 No                     |                       |                                 | s Decedent of H<br>es, specify Cub                     | lispanic Origi<br>an, Mexican, | in? (Speci<br>, Puerto Ri | ify Yes or No-<br>ican, etc.)              | ŀ                 |                      | e - Ameri<br>k, White,         | can Indian,<br>etc.                           |    |
| To Be Completed by Funeral Director | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced                             | If Yes, Give<br>Year or Dates:  | 1973                  | 1                               | Yes 2 No   | Specify:                       |                           |  |                   | Specify              | : Wh                           | ite   |    |
| etec                                | 15. Decedent's Ed<br>(Specify only highest gra                                     | lucation<br>de completed)   |                       | 16a. Deceder<br>(Give kir       | nt's Usual Occup<br>nd of work done<br>NOT use retired | ation<br>during most           | of working                | ,  | 16b. K            | ind of Bu            | isiness/In                     | ndustry                                       |    |
| m<br>D                              | Elementary/Secondary (0-12)  | College (1-4or 5+   |                       |                                 |  | 1)                             |                           |  |                   |                      | _                              |   |    |
| Ŝ                                   | d7 Falbania Nama (Final Adiada) ( ast)   | 5+  |                       | Engin                           | eer  | 40.14.11.1                     |                           |  |                   |                      |                                | es Army                                       | _  |
| Be                                  | 17. Father's Name (First, Middle, Last)  |   |                       |                                 |  |                                |                           | First, Middle,                             |                   | Surnam               | ie)                            |   |    |
| P                                   | Henry F. Schrader  |   |                       |                                 |  |                                |                           | chinbu                                     |                   |                      |                                |   |    |
|                                     | 19a. Informant's Name/Relationship (7  |   |                       |                                 | Address (Street  |                                |                           |  | -                 |                      |                                | ,   |    |
|                                     | Marium Schrader 20a. Method of Disposition   | / Wife  | 20h Pla               | 1034 I                          | Democrac   | y Lan                          | e Po                      | otomac,                                    |                   |                      |                                |   |    |
|                                     | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify                       |   | cer                   | netery, crema                   | tory or other plac<br>Cremator                         |                                |                           |  |                   |                      | ,                              | own, State<br>h, Va.                          |    |
| ij                                  | 21. Signature of Funeral Service Licen   | isee Q  |                       | 22. N                           | lame and Addre   | ss of Facility                 | Jose                      | eph Gaw                                    | ler               | 's S                 | ons,                           | Inc.  | Ī  |
| 1                                   | William K.   | Bugge   |                       | 513                             | 30 Wisco   | nsin A                         | Ave.                      | N.W. W                                     | lash              | ingt                 | on D                           | .c. 20016                                     |    |
|                                     | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only       | plications that caused to<br>one cause on each line                     | ne death.             | Do not enter                    | the mode of dyir                                       | ıg, such as c                  | cardiac or                | respiratory arr                            | est,              |                      |                                | Approximate<br>Interval Between               | ij |
| 1                                   | Immediate Cause (Final disease or condition  |   | MONI                  |                                 |  |                                |                           |  |                   |                      |                                | Onset and Death                               |    |
|                                     | resulting in death)  | Due to (or as a   |                       |                                 | -  | _                              |                           |  |                   |                      | _                              |   | -  |
|                                     | Constant the link one distance   | b   |                       |                                 |  |                                |                           |  |                   |                      |                                |   |    |
| ner                                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a   | conseque              | nce of):                        |  |                                |                           |  |                   |                      |                                |   | _  |
| ami                                 | Cause (Disease or injury that initiated events                                     | c   |                       |                                 |  |                                |                           |  |                   |                      |                                |   |    |
| Ĕ                                   | resulting in death) Last   | Due to (or as a   | conseque              | nce of):                        |  |                                |                           |  |                   |                      |                                |   |    |
| edical Examiner                     |  | d   |                       |                                 |  |                                |                           |  |                   |                      |                                |   | _  |
|                                     | IF FEMALE:   |   |                       |                                 |  |                                |                           |  |                   |                      |                                |   |    |
| an/                                 | 23b. Was decedent pregnant in the past 12 months?                                  | 23c. If yes, outcome pt<br>1 ☐ Live birth 2                             |                       |                                 | ctopic pregnancy                                       | ,                              |                           |  | -                 |                      | e of deliv                     | *   |    |
| sici                                | 1 ☐ Yes 2 ☐ No   | 4□Pregnant at ti<br>9□Unknown   | me of dea             | th 5□0                          | ther (specify)   |                                |                           |  |                   | Мо                   | ntn                            | Day Year                                      |    |
| Physician/M                         | 9 Unknown  |   |                       |                                 |  |                                |                           | 00.5                                       |                   |                      |                                |   |    |
|                                     | Part II. Other significant conditions co   | ontributing to death but  | not resulti           | ng in the unde                  | erlying cause giv                                      | en in Part I.                  |                           |  |                   |                      |                                | he cause of death?                            |    |
| Completed by                        |  |   |                       |                                 |  |                                |                           | 1 D Y                                      | es 2              | M No                 | 3 ☐ Prol                       | bably 4 □Unknown                              |    |
| ble                                 |  |   |                       |                                 |  |                                |                           | 24a. Was a                                 |                   | 24b. \               | Vere auto                      | opsy findings available ompletion of cause of |    |
| NO.                                 |  |   |                       |                                 |  |                                |                           | perfor<br>1∐ Yes                           | rced?<br>2 ☐ No   | ) 7                  | leath?                         | 2 No  |    |
| Be                                  | 25. Was case referred to medical examiner?   |   |                       |                                 |  |                                | of Death (                | Check only or                              |                   |                      |                                |   | _  |
| 2                                   | 1 ☐ Yes 2 ☐ XNo  | Hospital: 1 XInpatient  | 2 🗆 EF                | R/Outpatient                    | 3□ DOA Oth   | er:<br>4 🗆 Nurs                | sing Home                 | 5 ☐ Reside                                 | ence              | 6 □Oth               | er (Speci                      | fy)   |    |
|                                     | 27. Manner of Death  1 Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day                                      | (ear) 2               | 8b. Time of<br>Injury           | 28c. Injur<br>Wor                                      | y at<br>k?                     | 28                        | d. Describe h                              | ow inju           | ry occurr            | ed                             |   |    |
| atic                                | 2 ☐ Accident investigation   |   | -                     |                                 | M 1□   | Yes 2 □ N                      | lo                        |  |                   |                      |                                |   |    |
| <u>≅</u>                            | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined                            | 28e. Place of injury building, etc.                                     | - At hom<br>(Specify) | e, farm, street                 | , factory, office                                      |                                | 28                        | f. Location (S:<br>City or Town            | treet ar          | nd Numb              | er or Run                      | al Route Number,                              |    |
| Ce                                  |  |   |                       |                                 |  |                                |                           |  |                   | ,                    |                                |   |    |
| Medical Certification:              | 29a. Certifier  (Check only one)  1 X Certifying Phy 2 Medical Exam                | ysician: To the best of<br>niner: On the basis of e<br>and manner state | xaminatio             | edge, death o<br>n and/or inves | ccurred at the tire<br>stigation, in my c              | ne, date and<br>pinion, death  | d place, an<br>h occurred | d due to the c                             | ause(s<br>late an | ) and ma<br>d place, | nner as s<br>and due t         | stated.<br>to the cause(s)                    |    |
| ž                                   | 29b. Signature and title of certifier  |   |                       |                                 | 29c. Licens  | e number                       |                           | 2  | 9d. Da            | te signed            | (Month,                        | Day, Year)                                    |    |
|                                     | S. Mik.  |   |                       |                                 | AFE84  |                                | (CA)                      |  |                   |                      | 2008                           |   |    |
|                                     | 30. Name and address of person who see SEAN A. MCKAY I                             | completed cause of dea  |                       | 3a) (Type, Pri                  | 111)   |                                |                           | . <u>мертс</u><br>)889-56                  |                   | CENT                 | ER                             |   |    |
| e                                   | 31. Date filed (Month, Day, Year)  | 32 egistrar   | s Signatuı            | e ø                             | 20.20  |                                |                           |  |                   |                      |                                |   | _  |
| ır                                  | JAN 3 1 20   | 108 Seeve   | , B                   | Apa                             | E.   |                                |                           |  |                   |                      |                                |   |    |
| 34                                  |  |   |                       | -                               |  |                                |                           |  |                   |                      |                                |   |    |

Stat Registra

notified 1 and 2 should be filed within 72 hours after death with Health and Mental Hygiene. em 27 Is marked other than "natural", or Items 23a or wher traumatic event, the Medical Examiner must be in the traumatic event, the Medical Examine. Department of Health a Important: If item 27 Is any Injury or other trau Pages 1

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

burial-tran physician a the burial Division or Vital Records, P.O. Box 68760, signed t s certificate has b irector, page 2 sl To the Hospital or Attending Physician: the funeral director, 24 hours a

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** WILLIAM EUGENE SHUMAKER FEBRUARY 2008 4:42 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 217 LAKIN AVENUE EXT. **BOONSBORO** WASHINGTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 X M 2 □ F MARCH 24, Director 36 1971 MARYLAND 217-86-6043 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 Yes 2 No Directo WASHINGTON MARYLAND BOONSBORO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 217 LAKIN AVENUE EXT. 21713 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABORER 9 CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ NANCY ELLEN GATRELL RONALD ELWOOD SHUMAKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RONALD L. SHUMAKER/BROTHER 217 LAKIN AVENUE EXT., BOONSBORO, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CEDAR LAWN MEM. PARK 2/07/2008 HAGERSTOWN, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7606 Old National Pike BAST FUNERAL HOME Kelly A. Zimmermah Boonsboro, Maryland 21713 te, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Part 1. Enter the disease shock, or leart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) brother's Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 Tes 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State FEB 0 4 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

|   | _                   |     |    |   |
|---|---------------------|-----|----|---|
| State of Maryland / Department of Health and Mental Hyg  Certificate of Death | iene <sub>o n</sub> | 00  | 7) | n |
| Certificate of Death  | ed No               | U ( |    | 0 |

|                     |   |  | Certificate of Death  | Reg. No.  | 108 04354  |
|---------------------|---|--|---|---|--|
|                     | Physician   | Decedent's Name (First, Middle, Last)     Fred Lincoln Stough  |   | Date of Deeth     Month Dey                                 | 3. Time of Death<br>Year   |
|                     | /Medical  |  |   | January 27, 2008  |  |
|                     | Examiner  | 4a Fecility Neme (If not institution, give street end number)  | 4b. City, Town, or Lo   |   | ity of Death   |
|                     |   | Northampton Manor  5. Social Security Number 6. Sex 7. Age (In yrs. let  | Frederick st hirthday) If Under 1 Year   If Under 24 Hrs.   |   | rederick   |
| 3 -                 | Funeral<br>Director   | 5. Social Security Number 180–10–4716  Usuel Residence of Decedent  6. Sex 1 M 2 F 7. Age (In yrs. let   | Months Davs Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br>October 4, 1914   | Birthplece (State or Foreign Country)     Pennsylvania                               |
|                     | Maryland -f show find at  |  | Town or Location Frederick  |   | 10d. Inside City Limits 1 ☐ Yes ※※No   |
|                     | ifier death with the Main frems 23s or 28s-fs. Instrument be notified Funeral Director                  | 10e. Street and Number 911 Sweet Gum Court   | 10f. Zip Code<br><b>2170</b> 1  | 10g. Citizen o  | f What Country?  |
| Maryland 21215-0020 | by by   | 11. Marital Status  1 Never Merried 2 Married  1 Never Merried 4 Divorced  12. Was Decedent Ever in U,S. Armed Forces?  1 Never Merried 2 Married  12. Was Decedent Ever in U,S. Armed Forces?  1 Never Merried 2 Married  12. Was Decedent Ever in U,S. Armed Forces?  1 Never Merried 2 Married  12. Was Decedent Ever in U,S. Armed Forces?  1 Never Merried 2 Married  12. Was Decedent Ever in U,S. Armed Forces?  1 Never Merried 2 Married  12. Was Decedent Ever in U,S. Armed Forces?  1 Never Merried 2 Married  12. Was Decedent Ever in U,S. Armed Forces?  1 Never Merried 2 Married  12. Was Decedent Ever in U,S. Armed Forces?  1 Never Merried 2 Married  12. Was Decedent Ever in U,S. Armed Forces? | If Yes, specify Cuban, Mexican, Puerto I  | Rican, etc.) B  | ace - American Indian,<br>lack, White, etc.<br><sup>cify:</sup> <b>White</b>         |
| 2-0                 | ed within 72 hou ygiene.  For then "natura it, the Medical E  | 15. Decedent's Education (Specify only highest grade completed)  | 16e. Decedent's Usual Occupetion (Give kind of work done during most of working)                          | 16b. Kind of  | Business/Industry  |
| 7                   | within one one.  than 'n he Men'  | Elementary/Secondary (0-12) College (1-4or 5+)   | `life. DO NOT use retired)  |   | 1200 12  |
| 7                   | al Hygier<br>other th<br>vent, th   | 12<br>17. Fether's Neme (First, Middle, Last)  | Mechanic 18 Methodo Namo  | Self (First, Middle, Maiden Sumi                            | employed   |
| and                 | S S S S S S S S S S S S S S S S S S S   |  | Mary  |   | ybaugh   |
| 2                   | should be<br>ind Menta<br>imarked<br>umertic ev   | Charles M. Stough  19a. Informant's Name/Relationship (Type, Print) (Daughter)   | 19b. Mailing Address (Street and Number or Rure   |   |  |
|                     | 4 5 6 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5   | Mrs. Zoe S. U'Brien  | 911 Sweet Gum Court, 1  |   |  |
| ō                   | Peges 1 en<br>nent of Heali<br>int: If Item 2<br>iry or other   | 1 Burial 2 Cremation 3 MRemoval from State   | ce of Disposition (Name of netery, cremetory or other place)  Insylvania Cremation So                     | /31/2008  | n - City or Town, State  |
| Balti               | permit. Peg<br>Depertment<br>Important: I<br>any Injury o<br>once.                                      | 21. cnatur of Funeral Sprvice Licensee M-00849 Paul T. Lochstampf  | 22. Name and Address of Facility  | al Home, Inc.   | 8. 10  |
|                     |   | You! I try home HU   | 48 S. Church Stree  | te, Waynesbor   | o, PA 17268 Approximete  |
|                     | Physician   | 23a. Fart1. Enter the dise 11e, or complications that chus 1 Inc. leath. shock, or heart failure. List only one cause on each line.  | Do not enter the mode of dying, such as cardiac o   | r respiratory arrest,                                       | Interval Between<br>Onset and Death  |
| 16                  | /Medical  | Immediate Cause (Final disease or condition  | RY ARTORY DISCOSE   |   | YEARS  |
|                     | Fxaminer  | resulting in death)  | es a consequence of):   |   |  |
|                     | si ed   | b  |   |   |  |
|                     | executed<br>in end<br>iel-transit<br>Examiner   | Sequentially list conditions, if eny, leading to immediate   | as a consequence of):   |   |  |
| 68760,              | sician<br>sician<br>bunica<br>cai E   | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events Due to (or a   | and a constant of the   |   |  |
| 89                  | eath certificate be executed attending physician and for use as the buriel-transit clary/Medical Examir | resulting in death) Last   | is a consequence of):   |   |  |
| Box                 | ending<br>r use e   | d  |   |   | 1  |
|                     | death<br>ne atter<br>ed for u   | Part II. Other significant conditions contributing to death but not result   | ing in the underlying cause given in Part I.  | 23b. Did tobacco use  | contribute to the ceuee of death?  |
| P.O.                | that the death or the by the attend deteched for us.  |  |   | 1 □ Yes 2 □ No  | 3 ☐ Probably 4 ☐ Unknown   |
| cords,              | requires<br>been sign<br>should be<br>leted by  |  |   | 24a. Was an autopsy performed?                              | 24b. Were autopsy findings<br>aveilable prior to<br>completion of cause<br>of death? |
| æ                   | elay<br>hes<br>je 2   |  |   | 1□ Yes 2₽No   | 1 ☐ Yes 2 ☐ No   |
| <u>च</u>            | certificate rector, pag   | 25. Was case referred to medical   | 26. Place of Death  |   |  |
| ≥ :                 | Physician: this certific ral director,  | examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ El  | R/Outpatient 3□ DOA Other: 4□ Nursing Hor   | ne 5 Residence 6 C  | Other (Specify)  |
| 0 0                 | ding Ph.<br>h.<br>After thi<br>funeral  | 1 ☐Naturel 5 ☐ Pending (Month, Dey Year)   | 8b. Time of Injury At Work?  M 1 Yes 2 No   | 28d. Describe how injury occ                                | urred  |
| <b>5</b>            | or Atten<br>effer deet<br>Director:<br>In by the  | 2 □ Accident   |   | 28f. Location (Street and Nur<br>City or Town, Stete)       | mber or Rural Route Number,  |
| ;                   | the Hospital hin 24 hours the Funeral upletely filled   | 29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge of examination and manner stated.   | edge, death occurred at the time, date and place, a in end/or investigation, in my opinion, death occurre | and due to the cause(s) and led at the time, date and place | manner as stated.<br>e, and due to the cause(s)                                      |
|                     | Within 2  | 29b. Signature and title of certifier  | 29c. License number   |   | ned (Month, Dey, Yeer)<br>7 / 2008   |
|                     | 7   | 30. Neme and eddress of person who completed cause of death (Item 2) Dr. Richard Gough   |   |   |  |
| 10                  | State<br>Registrar  |  |   |   |  |
|                     |   |  |   |   |  |

DHMH 16 Rev 6/95

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|             |   |                | For<br>State<br>Registrar   | State of Mar  | yiand /                 |                       | rtificate of L  |                                 | na ivier                    |                              | jiene<br>leg. No.      | 2008  | 04355                           |
|-------------|---|----------------|---|---|-------------------------|-----------------------|---|---------------------------------|-----------------------------|------------------------------|------------------------|---|---------------------------------|
| T           | Physicia  | an             | Decedent's Name (First, Middle, Las   |   |                         |                       |   |                                 |                             | Date of Dea<br>Month         | Day                    |   | 3. Time of Death                |
|             | /Medic  | al             | Dorothy  4a. Facility Name (If not institution, give  | Strick1   | and                     | Т                     | 4b. City, Town, or  | Location of                     |                             | anuary                       |                        | 2008 County of Death                                | 12:50a <sup>M</sup>             |
|             | Examin  | er             | Manor Care Nurs   | ,   |                         |                       | Silver  |                                 |                             |                              |                        | iont gome   | <b>r</b> v                      |
|             | Funeral   |                | 5. Social Security Number 6. Se   | ex 7. Age   | 'In yrs. last b         | irthday)              | If Under 1 Year   | If Under 2                      | 4 Hrs. 8.                   | Date of Birth<br>(Month, Day | )                      | 9. Birthp   | lace (State or Foreign          |
|             | Director  |                | 251-/4-4833   | □M 21K_] F  | 64                      | Yrs.                  | Months Days   | Hours                           |                             | ct. 21                       |                        | 043 Chest   | er, S.C.                        |
|             | and ww  |                | Usual Residence of Decedent  10a. State 10b. County   | 1   | 0c. City, Tov           | vn or Lo              | cation  |                                 |                             |                              |                        | 1   | 0d. Inside City Limits          |
|             | Maryl<br>-f sho<br>fied a   | tor            | Maryland Prince Ge  | orcos   | lyatts                  | 417                   | 0   |                                 |                             |                              |                        |   | 1 ☑ Yes 2 ☐ No                  |
|             | r 28a   | Director       | 10e. Street and Number  | orges II  | iyatts                  | <u> </u>              | 10f. Zip Code   |                                 |                             | 1                            | 10g. Citi              | zen of What Coun                                    | try?                            |
|             | th wit  | alD            | 1907 Palmer Park R  | oad   |                         |                       | 20785   |                                 |                             |                              | Uni                    | ited Stat   | es                              |
|             | ems   | Funeral        | 11. Marital Status  | 12. Was Decedent Ev<br>Armed Forces?                  | er in U.S.              | 13. V                 | Was Decedent of Hi<br>f Yes, specify Cuba                         | spanic Orig<br>n, Mexican,      | in? (Specify<br>Puerto Rica | Yes or No-<br>an, etc.)      |                        | <ol> <li>Race - Americ<br/>Black, White,</li> </ol> |                                 |
| 5-0036      | ges 1 and 2 should be filed within 72 hours after death with the Maryland to the Hall and Mental Hygiene.  If of Health and Mental Hygiene.  If health and Mental Hygiene.  If health and Mental Hygiene.  If health and Mental Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at | by             | 1 ☐ Never Married 2 ☐ Married<br>3 🛱 Widowed 4 ☐ Divorced   | Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates: |                         |                       | I∐Yes 2∏xNo   | Specify:                        |                             |                              |                        | Specify: Blac                                       | ck                              |
| ဂ           | 72 ho<br>'natur<br>dical  | Completed      | 15. Decedent's Ed<br>(Specify only highest grad   | ucation<br>de completed)                              | 16                      | a. Deceo              | lent's Usual Occupa<br>kind of work done of<br>OO NOT use retired | ation<br>Juring most            | of working                  |                              | 16b. Ki                | nd of Business/Ind                                  | dustry                          |
| 7           | within<br>iene.<br>than "<br>he Mec   | mp             | Elementary/Secondary (0-12)   | College (1-4or 5+)                                    | <b>I</b>                |                       |   | )                               |                             | ,                            | nt                     | -4  |                                 |
| N           | filed v<br>Hygie<br>other 1   |                | 17. Father's Name (First, Middle, Last)   |   |                         | Nurs                  | e Aide  | 18. Mother                      | 's Name <i>(Fi</i>          | irst, Middle,                | <u>Priv</u><br>Maiden  |   |                                 |
| and         | ould be<br>Mental<br>arked o  | To Be          | Reuben Hogan  |   |                         |                       |   | Sadie                           | e Maco                      | n                            |                        |   |                                 |
| 3           | 2 should be<br>and Mental<br>Is marked<br>aumatic ev  | -              | 19a. Informant's Name/Relationship (7   | Type. Print)  | 19                      | b. Mailin             | g Address (Street a   |                                 |                             |                              | r, City o              | r Town, State, Zip                                  | Code)                           |
| Ĕ           | and 2   |                | Tiwana Young / Dau  | ghter   | 27                      | 12 M                  | iill Valle  | ey Ct.                          | . Matt                      | hews,                        | Nor                    | th Carol  | ine 28105                       |
| e)<br>G     | of He fitem   |                | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  | Removal from State                                    | 20b. Place<br>cemet     | of Dispo<br>ery, cren | sition (Name of<br>natory or other plac                           | e) :                            | Date                        | ,                            | 20c. Lo                | cation - City or To                                 | wn, State                       |
| E .         | Pages<br>ment of l<br>ant: If it  |                | 4 □ Donation 5 □ Other (Specify   | )   | Resur                   |                       | ion Cemet   |                                 |                             |                              |                        | ton, Mar  | yland                           |
| palt        | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.  |                | 21. Signature, of Funeral Service Limin   | see M 010e  | 4                       | 22                    | Name and Address Alexander 5538 Mar:                              | s of Facility<br>r S I<br>Lboro | PPRe/                       | P.A.<br>Fores                | tvi]                   | le, Md.   | 20747                           |
|             |   |                | 23a. Part1. Enter the disease, or composhock, or heart failure. List only of                                |   |                         |                       |   |                                 |                             |                              |                        |   | Approximate<br>Interval Between |
|             | Physician   |                | Immediate Cause (Final disease or condition   | Sacral  | Ulce                    | r                     |   |                                 |                             |                              |                        |   | Onset and Death                 |
|             | /Medical  |                | resulting in death)   | a<br>Due to (or as a                                  | consequence             | e of):                |   |                                 |                             |                              |                        |   |                                 |
|             | Examiner  | L              | Sequentially list conditions.   | b. Osteomy  |                         |                       |   |                                 |                             |                              |                        |   |                                 |
|             | ed sit  | ine            | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a                                       | consequence             | of):                  |   |                                 |                             |                              |                        |   |                                 |
|             | and<br>al-tran  | Examiner       | that initiated events<br>resulting in death) Last   | c<br>Due to (or as a                                  | consequence             | e of):                |   |                                 |                             |                              |                        |   |                                 |
| 58/50,      | ificate be executed<br>physician and<br>as the burial-transit   |                |   | .d  |                         |                       |   |                                 |                             |                              |                        |   |                                 |
|             |   | <b>ledical</b> |   |   | 27.7.7                  |                       |   |                                 |                             |                              |                        |   |                                 |
| X<br>R<br>R | death cert<br>e attending<br>d for use a  | an/N           | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  | 23c. If yes, outcome pr                               | pregnancy<br>□Fetal dea | th 3□                 | ∃Ectopic pregnancy  |                                 |                             |                              | 100                    | 23d. Date of delive<br>Month                        | ery<br>Day Year                 |
| 5           | w requires that the death certil<br>been signed by the attending<br>should be detached for use a  | Physician/M    | 1 Yes 2 No  | 4□Pregnant at ti<br>9□Unknown                         | me of death             | 5                     | Other (specify)   |                                 |                             |                              |                        | WOTH  | Day real                        |
| 7.          | requires that the<br>een signed by the  |                | Part II. Other significant conditions of  | ontributing to death but                              | not resulting           | in the ur             | nderlying cause give  | en in Part I.                   |                             | 23e. Did to                  | bacco u                | use contribute to the                               | he cause of death?              |
| ďs,         | luires<br>n sign<br>ld be   | d by           | Liver Transplant  |   |                         |                       |   |                                 |                             | 1 □ Y                        | es 2                   | No 3□ Prob  | pably 4 □Unknown                |
| ecord       | law rec<br>as beer<br>2 shou  | lete           | Hypertension  |   |                         |                       |   |                                 |                             | 24a. Was a                   |                        | 24b. Were auto                                      | ppsy findings available         |
| 2           | siclan: The law<br>s certificate has the lirector, page 2 s   | Completed      |   |   |                         |                       |   |                                 |                             | autop<br>perfoi<br>1∐ Yes    | rmed?<br>2 <b>X</b> No | death?  | mpletion of cause of            |
| VITAI H     | lan:<br>rtifica<br>stor, p  | Be C           | 25. Was case referred to medical examiner?  |   |                         |                       |   | 26. Place                       | of Death (C                 | heck only o                  |                        |   |                                 |
|             | Physiclan:<br>r this certific<br>ral director,  | To E           | 1 Yes 2 No  | Hospital: 1 ☐ Inpatien                                | 2 ER/C                  | Outpatien             |   | 4124 Nur                        | rsing Home                  | 5 🗆 Resid                    | lence                  | 6 □Other (Specia                                    | (y)                             |
| 0           | ding Pi   |                | 27. Manner of Death 1 X Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day                    |                         | . Time of<br>Injury   | Worl  |                                 | Į                           | I. Describe h                | now injui              | ry occurred   |                                 |
| <u> </u>    | ttend<br>leath.<br>tor: /<br>the fi   | cati           | 2 Accident investigation 3 Suicide 6 Could not be   | the second second second second                       | 4 - At homo             | form etr              |   | Yes 2 □ N                       |                             | Location /S                  | Stroot ar              | nd Number or Rura                                   | al Poute Number                 |
| UIVISION    | ne Hospital or Attending P<br>n 24 hours after death.<br>ne Funeral Director: After toletely filled in by the funeral   | ertification:  | 4 ☐ Homicide determined   | building, etc.  | (Specify)               | iaiii, su             | eet, factory, office  |                                 | 201.                        | City or Tow                  | vn, State              | )   | ai riodie Nailibei,             |
|             | spital<br>nours<br>nerai<br>/ filled  | C              | 29a. Certifier 1 Certifying Ph  | ysician: To the best of                               | my knowled              | ge, deati             | h occurred at the tir   | ne, date an                     | d place, and                | d due to the                 | cause(s                | ) and manner as s                                   | tated.                          |
|             | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,   | edical         | (Check only 2 Medical Exan  | niner: On the basis of e<br>and manner state          |                         | and/or in             | vestigation, in my o  | pinion, deat                    | th occurred                 | at the time,                 | date an                | d place, and due t                                  | o the cause(s)                  |
|             | To the within 2 To the complete   | Me             | 29b. Signature and title of certifier   | //.   |                         |                       | 29c. Licens   |                                 |                             |                              |                        | te signed (Month,                                   |                                 |
| )           | ,   |                | Vaus  | sec   | 1                       |                       | 00532   | 35                              |                             | J                            | an.                    | 30, 2008  | 5                               |
| 1           | 2/5/  |                | 30. Name and address of person who  |   |                         |                       |   |                                 | 00=0=                       |                              |                        |   |                                 |
| 1           | - 0   | 10             | Darryl Hill 13635 31. Date filed (Month, Day, Year)   | Baltimore 32. Registrar                               |                         | Lauı                  | cel, Mary   | Land 2                          | 20707                       |                              |                        |   |                                 |
|             | Sta<br>Registr  |                | FEB 0 1 2008  |   | Los                     | Bi                    |   |                                 |                             |                              |                        |   |                                 |
|             |   |                | L L U U . A Pro-  | KANAL PROPERTY.                                       | -                       | -                     |   |                                 |                             |                              |                        |   |                                 |

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DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Quentin T. Sisney Certificate of Death Reg. No. 1- For State 3. Time of Death 2. Date of Death Registrar 1. Decedent's Name (First, Middle,Last) Year 1205 hrs February 1, 2008 ysician/ Theodore 4c. County of Death Ouentin xaminer Med 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Hours Country) CA **Funeral** Months Days Sept 28, 1966 41 549-25-4816 Director 1X M 2 F 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No Gaithersburg Montgomery "natural", or items 23a or 28a-f show Examiner must be notified at once. MD10g. Citizen of What Country? 10f. Zip Code Director 10e. Street and Number USA 20886 14. Race - American Indian, Black, 19431 Brassie Place 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: White Yes 2X No specify: If Yes, Give Year permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner. Divorced Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Dccupation (Give kind of work done ģ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DD NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) <u>Hospitality</u> Computer Programmer 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carrie Ann Wise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Quentin Melvin Sisney Be 19a. Informant's Name/Relationship (Type, Print ) 3400 Mona Way Bakersfield, 93309 Q Murita Conner/sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State saltimore, Beltsville, MD 02/09/08 Chesapeake Crematory Other Specify Donation 5 22. Name and Address of Facility Going Home Cremation Service P. Reverly I. Heckrotte, P.A. Clark Beverly I. Heckrotte, P.A. Clark Case. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he P.O. Box 784 Approximate Inte Between Onset and Death sician failure. List only one cause on each line. Hypertensive cardiovascular disease Medical Immediate Cause (Final disease Due to (or as a consequence of): Examiner or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi Physician/Medical X UNPENDED A#2532,PII,27,perME,g876, 2/20/08 TI attending physician or use as the burial 23d. Date of delivery 23c. If yes, outcome of pregnancy Year Box 68760, Day Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? signed by the a Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown of Vital Records, P.O. ģ Fatty Liver 24b. Were autopsy findings available 24a. Was an prior to completion of cause of Completed as been s autopsy death? performed? has ✔ Yes 2 certificate 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death. Dther Nursing Home 5 Residence 6 Other æ examiner? Inpatient 2 V ER/Dutpatient 3 28d. Describe how injury occurred this 1 V Yes 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After 1 Yes 2 No Certification: 1 X Natural 5 Pending 28f. Location (Street and Number or Rural Route Number, City Division the Director: Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 Accident or Town, State) Could not be Suicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Homicide 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year) and manner stated. 29c. License number 29b. Signature and title of certifier February 2, 2008 O.C.M.E. Juthall 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner t)023 Pamela E. Sputhall, MD

State

Registrar

31. Date filed (Mo

32. Registrar's Signature

Made and

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036

Dir

1 - For State Registrar

Phys /Me Exan

o the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division or Vital Records, P.O. Box 68760,

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|-------|----|
| 8     | \  |
| 1.4   | St |

| sicia:<br>edica |                | John Donald  | Tennyson, S:   | r.  |   |   | Februar                                      | y 3, 2008                                | 3:45 P <sub>M</sub>                                     |  |  |  |
|-----------------|----------------|--|--|---|---|---|--|--|---|--|--|--|
| mine            |                | 4a. Facility Name (If not institution  | , give street and number)                              |   | 4b. City, Town, o                                       | or Location of Death                      | 1  | 4c. County of D                          | eath  |  |  |  |
|                 | Ų.             | 24410 Maddox   | Road   |   | -   | Chaptic                                   | 0  | St.                                      | Mary's  |  |  |  |
| ral<br>tor      |                | 5. Social Security Number 216–60–3733  | 6. Sex 7. Ag   | ge (In yrs. last birthday)<br>93 Yrs.           | If Under 1 Year<br>Months Days                          | If Under 24 Hrs.<br>Hours Min.            | 8. Date of Birth<br>(Month, Day,<br>December | Year)                                    | Birthplace (State or Foreign<br>Country)<br>laryland    |  |  |  |
|                 | -              | Usual Residence of Decedent  10a. State 10b. County  |  | 10d. Inside City Limits                         |   |   |  |  |   |  |  |  |
|                 | ۵ ا            |  |  |   | 1 ☐ Yes 2X No   |   |  |  |   |  |  |  |
| 1               | Director       | Maryland St.  10e. Street and Number   | Mary's   |   | Chapt<br>10f. Zip Code                                  | 1 <b>c</b> o                              | 10   | 0g. Citizen of What                      |   |  |  |  |
| i               | 5              | 24410 Maddox Ro  | nad  |   | Tot. Zip Code   | 20621                                     | 1  | US.                                      |   |  |  |  |
|                 | Funeral        | 11. Marital Status   | 12. Was Decedent                                       | Ever in U.S. 13                                 | Was Decedent of F                                       |   | necify Ves or No.                            |  | Merican Indian,   |  |  |  |
|                 |                | 1 □ Never Married 2 □ Marri  | Armed Forces?  |   | If Yes, specify Cub                                     | tispanic Origin? (S<br>an, Mexican, Puert | o Rican, etc.)                               |  | Vhite, etc.   |  |  |  |
|                 | 2              | 3 ☐ Widowed 4 🎦 Divorced   | If Yes, Give<br>Year or Dates:                         |   | 1 □ Yes 2 No  | Specify:                                  |  | Specify: V                               | √hite   |  |  |  |
|                 | Completed      | 15. Decedent   |  |   | dent's Usual Occup                                      | oation<br>during most of wor              | fring.                                       | 16b. Kind of Busine                      | ess/Industry  |  |  |  |
| ľ               | e l            | (Specify only highes<br>Elementary/Secondary (0-12)  | College (1-4or 5                                       | 5+) life.                                       | DO NOT use retire                                       | d) auring most or wor                     | King   |  |   |  |  |  |
| d               | 5              | 8  |  | Wate  | rman  | Г   |  | Seafoo                                   | d   |  |  |  |
|                 | ne<br>ne       | 17. Father's Name (First, Middle,  | ,  |   |   |   | ne (First, Middle, N                         |  |   |  |  |  |
|                 | <u> </u>       | George S. Tennyson  Mary Ruth Mattingly  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |   |   |   |  |  |   |  |  |  |
|                 |                | 19a. Informant's Name/Relationship (Type. Print)  John Donald Tennyson, Jr. / Son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  37590 Demby Hill Lane Avenue, MD 20609   |  |   |   |   |  |  |   |  |  |  |
|                 | -              | John Donald Tennyson, Jr. / Son 37590 Demby Hill Lane Avenue, MD 20609  20a. Method of Disposition (Name of Dispos |  |   |   |   |  |  |   |  |  |  |
|                 |                | 20a. Method of Disposition<br>1 ⊠ Burial 2 □ Cremation   | 3 ☐Removal from State                                  | cemetery, cre                                   | matory or other pla                                     | ' HADIN                                   | Date 2                                       | 20c. Location - City                     | or Town, State  |  |  |  |
|                 |                | 4 □ Donation 5 □ Other (Sp   |  | St. Joseph                                      |   |   | 2008   | Morganza, N                              | Maryland  |  |  |  |
|                 |                | 21. Signature of Funeral Service   | Licensee   | 2:  | <ol> <li>Name and Address</li> <li>Mattingle</li> </ol> | y-Gardiner                                | Funeral Ho                                   | me. P.A.                                 |   |  |  |  |
| _               | -              | 1 panaexz  | maine  | v I   | P.O. Box  | 270 Leonai                                | rdtown, MD                                   | 20650                                    |   |  |  |  |
| ı               |                | 23a. Part . Enter the disease, or shock, or heart failure. List  | complications that caused<br>only one cause on such li | d the death. Do not en<br>ne.                   |   | 0.020                                     |  |  | Approximate<br>Interval Between<br>Onset and Death      |  |  |  |
|                 | ĺ              | Immediate Cause (Final disease or condition  | _a. A/h  | uvide   | rolec   | Con                                       | Ow Ve  | weelan                                   | Onset and Death   |  |  |  |
| ı               |                | resulting in death)  | Due to (or as  | a consequence of):                              |   |   |  |  |   |  |  |  |
| I.              |                | Sequentially list conditions,  | b  |   |   |   |  |  |   |  |  |  |
| 3               | III            | Sequentially list conditions, if any leading to immediate cause. Enter Underlying  | Due to (or as:   | a consequence of):                              |   |   |  |  | -9  |  |  |  |
| -               | Examiner       | Cause (Disease or injury<br>that initiated events<br>resulting in death) Last  | C. Duo to (or as                                       | a consequence of):                              |   |   |  |  |   |  |  |  |
|                 |                | ,  | Due to (or as  | a consequence oi).                              |   |   |  |  |   |  |  |  |
| 118             | 5              |  | d  | ***************************************         |   |   |  |  |   |  |  |  |
| 18.8            | sician/Medical | IF FEMALE:   | 23c. If yes, outcome                                   | of pregnancy                                    |   |   |  | 20d Date of                              | delle see   |  |  |  |
| -               | clan           | 23b. Was decedent pregnant in the past 12 months?  | 1 ☐Live birth<br>4 ☐ Pregnant at                       | 2 Fetal death 3                                 | Ectopic pregnanc Other (specify)                        | у   |  | 23d. Date of<br>Month                    | Day Year  |  |  |  |
| -               | S              | 1 □ Yes 2 □ No<br>9 □ Unknown  | 9□ Unknown   | t anno or dodair                                |   |   |  |  |   |  |  |  |
| ć               | Z Z            | Part II. Other significant condition   | ns contributing to death b                             | ut not resulting in the u                       | nderlying cause giv                                     | en in Part I.                             | 23e. Did tob                                 | acco use contribute                      | e to the cause of death?                                |  |  |  |
|                 | o c            |  |  |   |   |   | 1 <u></u> Ye                                 | s 2∐No 3∐                                | Probably 4 Nnknown                                      |  |  |  |
| 44              | Completed      |  |  |   |   |   | 04. 111                                      | 1  |   |  |  |  |
| -               |                |  |  |   |   |   | 24a. Was an<br>autopsy<br>perform            | y prior                                  | autopsy findings available<br>to completion of cause of |  |  |  |
|                 |                |  |  |   |   |   | 1⊟ Yes 2                                     | No 1 Y                                   |   |  |  |  |
|                 | D C            | 25. Was case referred to medical examiner?   | Hospital:  |   |   |   | th (Check only one                           | 9)                                       | *   |  |  |  |
| ŀ               | 2              | 1 Yes 20 No  | 1 inpatie  |   |   | 4 LI Nursing H                            |  | nce 6 Other (S                           | Specify)  |  |  |  |
| -               | 5              | 27. Manner of Death 1  | 28a. Date of Inju<br>(Month, Da                        |   | Wo  |   | 28d. Describe ho                             | w injury occurred                        |   |  |  |  |
| 1400            | 22             | 2 Accident investig  | not be   |   |   | Yes 2 □ No                                |  |  |   |  |  |  |
| 1               | Ceruncation:   | 4 ☐ Homicide determi   |  | ury - At home, farm, sti<br>c. <i>(Specify)</i> | eet, factory, office                                    |   | City or Town                                 | reet and Number or<br>, State)           | r Rural Route Number,                                   |  |  |  |
|                 |                | 00-0-45  | Dt. defendance   | -6  | L   |   |  |  |   |  |  |  |
| line.           | Medical        | 29a. Certifier Check only one) Certifyin 2 Medical   | g Physician: To the best<br>Examiner: On the basis o   | f examination and/or in                         | n occurred at the ti<br>vestigation, in my              | me, date and place<br>opinion, death occu | , and due to the ca<br>irred at the time, da | luse(s) and mannel<br>ate and place, and | r as stated.<br>due to the cause(s)                     |  |  |  |
| MACO            | Me             | 29b. Signature and title of certifier  | and manner sta   | aicu.   | 29c. Licens   | se number                                 | 20   | 9d. Date signed (M                       | onth. Day, Year)  |  |  |  |
|                 |                | 1211   | -1-  |   | 'X'   | 1625-                                     |  | 7 . ( ]                                  | -00   |  |  |  |
|                 | -              | , vully  | 1 The rus  |   | 10/   | 4042                                      |  | 2-7                                      | 08  |  |  |  |
|                 |                | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William D. Boyd, II, M.D. 25365 Point Lookout Road Leonardtown, MD 20650  |  |   |   |   |  |  |   |  |  |  |
|                 |                | 31. Date filed (Month, Day, Year)  | 32. <b>G</b> gistr                                     | ar's Signature                                  | A W   |   | 20000  |  |   |  |  |  |
| ate             |                | FFB 0  | 5 2008   | en B  | DOOR S  |   |  |  |   |  |  |  |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 5 Month **Physician** 8:12 P M February Dorothy Beatrice 2008 Thompson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Nursing Center St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. 8. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 🔀 F 220-16-7300 85 February 16,1922 Director Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 No Maryland St. Mary's Director Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or death with 25140 Vista Road ns 23a must b 20636 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or iter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. þ Specify: White 3 X Widowed 4 ☐ Divorced Completed th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School 1 Cafeteria Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernard S. Dean Ethel Gatton ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Hoopengardner / Daughter 25140 Vista Road Hollywood, MD 20636 item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important; If ite any injury or ot once. February 11, 1 

■ Burial 2 

□ Cremation 3 

□ Removal from State Hollywood Church of the Hollywood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 Nazarene Cemetery 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home,
P.O. Box 270 Leonardtown, MD 20 Approximate Interval Between Onset and Death 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ne. Immediate Cause (Final Physician N.A. disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has t irector, page 2 s autopsy performed 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27 Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital 29a. Certifier 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 0 rson who completed cau of death (Item 23a) (Type, Print) James P. Jarboe, M.D. 24035 Three Notch Road Hollywood, MD 20636 atrar's Signature 32. Hea 31. Date filed (Month, Day, Year) State 2008

Registra

FEB 0 8

|  |   |  | 1- State of Maryland / Department of Heal<br>Certificate of Deal  |                               |                            | eg. No.   | 3 04359                                |
|--|---|--|---|-------------------------------|----------------------------|---|--|
| П  | Physici   | an   | 1. Decedent's Name (First, Middle, Last) Arlene Ann Tordik  |                               | Date of Deat<br>Month      | Day Yea   | M                                      |
| /Medic<br>Examin                                     |   |  | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Local  |                               | Jan 2                      | 28, 2008<br>4c. County of De<br>Montq   | 6:10 pm omery                          |
| Funeral 5. S   |   |  |   |                               | Date of Birth              | 9.6   | Firthplace (State or Foreign           |
|  | Director  |  | 157-30-1644 1□ M 2 F 65 Yrs. Months Days Hou  | ours Min.                     | (Month, Day, 5/02/         | 1942 N  | ew Jersey                              |
|  | be filed within 72 hours after death with the Maryland Hygiene. Hygiene. dother than "natural" or liems 23a or 28a-f show event, the Medical Examiner must be notified at   | Funeral Director   | 10a. State 10b. County 10c. City, Town or Location 10b. County 10c. City Town or Location 10b. County 10c. City Town or Location 10b. County 10c. City Town or Location 10c. City Town |                               |                            |   | 10d. Inside City Limits 1   Yes 2  No  |
|  |   |  | 10e. Street and Number 10f. Zip Code  |                               | 1                          | 0g. Citizen of What   |  |
|  |   | ral Di   | 5 Cypress Grove Lane 32174  |                               |                            | USA   |  |
| 036  |   | by   | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  11. Was Decedent of Hispani If Yes, specify Cuban, Me  11. Was Decedent of Hispani If Yes, specify Cuban, Me  11. Was Decedent of Hispani If Yes, specify Cuban, Me  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispani If Yes, specify Cuban, Me  14. Was Decedent of Hispani If Yes, specify Cuban, Me  15. Was Decedent of Hispani If Yes, specify Cuban, Me  16. Yes, Give Year or Dates:   |                               | y Yes or No-<br>can, etc.) | 14. Race - Ai<br>Black, W<br>Specify:   | nerican Indian,<br>hite, etc.<br>White |
| 21215-0036   |   | oletec   | 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired)  | g most of working             |                            | 16b. Kind of Busine   |  |
| 212  | filed within 72<br>Hygiene.<br>hther than "na<br>ant, the Medic   | Completed  | Elementary/Secondary (0-12) College (1-4or 5+) Violations C   |                               |                            | Municip   | ality                                  |
| and  | s 1 and 2 should be fil<br>f Health and Mental H<br>ftem 27 Is marked oth<br>other traumatic even   | To Be  | 17. Father's Name (First, Middle, Last) Walter Aravich  | Olga I                        |                            | Maiden Surname)<br>1  |  |
| , Maryland   |   |  | 19a. Informant's Name/Relationship (Type. Print)Daughter Patricia A. Tordik, D. M. D. / 8617 Agusta F   | Number or Rural F<br>Farm Lai | Route Number<br>ne Gai     | ; City or Town, State<br>ithersbu   | rg, Zip Code)<br>rg, Md20882           |
| Baltimore,   | 5 = 5   |  | 20a. Method of Disposition  1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \   | 1                             | 2008                       | •   | New Jersey                             |
| Balt   | permit. Pag<br>Department<br>Important:<br>any Injury once.   |  | 21. Signatu Funeral Servic Ucensee PAR Transpar Agres Roll 9241 Columb  | oia Blv                       | d.Sil                      | ver Spri  | CE,P.A.<br>ng,Md20910                  |
|  | Ne de la constant   |  | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final  |                               |                            |   |  |
|  | Physician /<br>/Medical   |  | disease or condition resulting in death)  a.   OVAR.AV CAMER  Due to (or as a consequence of):  |                               |                            |   |  |
|  | Examiner  | er   | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):  |                               |                            |   |  |
|  | tificate be executed<br>g physician and<br>as the burial-transit  | Examiner   | Sequentially list conditions, if any, leading to immediate cause Find Index in Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  |                               |                            |   | 11                                     |
| 68/60,   | icate be executed<br>physician and<br>s the burial-transit  | Medical Certification: To Be Completed by Physician/Medical E) | Due to (or as a consequence of):  |                               |                            |   |  |
| Division or Vital Records, P.O. Box 68               | certifica<br>ding phy<br>se as th   |  | IF FEMALE: 23c. If yes, outcome pf pregnancy  | -                             |                            | 22d Date of   | dolivory                               |
|  | Hospital or Attending Physician: The law requires that the death certifi 4 hours after death.  4 hours after death.  4 hours after death.  5 hours after death.  6 hours after death.  7 here the attending it left this certificate has been signed by the attending it left filled in by the funeral director, page 2 should be detached for use as |  | s decedent pregnant he past 12 months?  I Clive birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)  Unknown  23d. Date of delivery  Month Day Year  |                               |                            |   |  |
|  |   |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                               |                            | 23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown |  |
|  |   |  |   |                               | 24a. Was a autops perform  | sy prior  |  |
|  |   |  | 25. Was case referred to medical examiner?  1   |                               |                            |   |  |
|  |   |  | 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Describe how injury occurred Work?   |                               |                            |   |  |
|  |   |  | 2 Accident investigation M 1 Yes 2 No   |                               |                            | 8f. Location (Street and Number or Rural Route Number,<br>City or Town, State)                |  |
|  | To the Hospital or A<br>within 24 hours after<br>To the Funeral Dire<br>completely filled in by   |  | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only one)   |                               |                            |   |  |
| )  | To the I  | Me   | 29b. Signature and the discritifier  29c. License num  3 5 6  | 35                            |                            | 9d. Date signed (M  | 29, 2008                               |
|  |   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  | n oin                         | By, r                      | ND 20   | 832                                    |
| State Registrar  JAN 3 1 2008  Registrar's Signature |   |  |   |                               |                            |   |  |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician LOUISE TURNER Januar 2008 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner Plato Medica Civista 5. Social Security Number If Under Date of Birth (Month, Day, Year) Age (In yrs. last birthday 9. Birthplace (State or Foreign Funeral 1 □ M 2 □ X Months Days Hours BOWMAN. 247-74-2380 66 Director SC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show notified at 1 Yes 2 No PRINCE GEORGE ACCOKEEK Director MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or Items 23a or Examiner must be 15512 MAIN BOULEVARD 20607 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√√No Specify Specify: BLACK þ 3 Vidowed 4 ☐ Divorced "natural" Completed Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natu any Injury or other traumatic event, the M-di.al 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry LOASE & SHERREE Elementary/Secondary (0-12) 12TH GRADE College (1-4or 5+) BEAUTICIAN HOUSE OF GLAMOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be ပ **JAMES** WESTBURY FLOSSIE WILLIAMS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERREE 15512 MAIN BOULERVARD, ACCOKEEK, MD 20607 LEE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 2-2-08 CLINTON, MD permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. 524 - 8TH ST., N. E. WASH., DC 20002-5236 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death t enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) ailure **Physician** /Medical Due to (or all a consequence of): Examiner failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-transit that the death certificate be executed Physician/Medical attending p as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 ☐ Live birth 2 Fetal death in the past 12 months? 1 Yes 2 No 9 Unknown Month Year 4□Pregnant at time of death by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been signal Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page certificate 2□No 1⊟ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2000 1 ☐ Yes P npatient 2 ER/Outpatient 3□ DOA After this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Box 68760 0 م Records. Division or Vital

Baltimore, Maryland 21215-0036

Hospital or Attending within 24 hours after death to the Funeral Director: completely filled in by the

> State Registrar

Medical

(Check only one)

Manisha

29b. Signature and title of cortifier

31. Date filed (Month, Day, Year) FEB 0 1 2008

Jariiyala

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature Is sport

MD 11637

lemace

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Dr. Suite 103 Waldorf, MD 20607

|            |   |                  | Please   | Type or Prin  |                                |  |                                 |                       | =                              |                         | _            | le.        |                                    |                     |
|------------|---|------------------|--|---|--------------------------------|--|---------------------------------|-----------------------|--------------------------------|-------------------------|--------------|------------|------------------------------------|---------------------|
|            |   |                  | For<br>State<br>Registrar  | State of Ma   | •                              | epariment (<br>Certificate                 |                                 |                       | ientai Hy                      | /gien<br>Reg. N         | 201          | 18         | 04                                 | 361                 |
|            |   | 100              | Registrar     Decedent's Name (First, Middle, L.   | ast)  |                                | Jorimouto                                  | or Boar                         | .,                    | 2. Date of De                  | eath                    |              |            | 3. Time                            | of Death            |
|            | Physici<br>/Medic   |                  | Jayra Cecelia T  | urnbull   |                                |  |                                 |                       | Month –                        |                         | ay 200       | Year<br>18 | 7:09                               | 9 P <sup>M</sup>    |
|            | Examin  |                  | 4a. Facility Name (If not institution, gi  |   |                                | 4b. City, To                               | wn, or Location                 | n of Death            |                                |                         | c. County o  |            |                                    |                     |
|            |   |                  | Bowie Health Ce  |   |                                | Bowie                                      |                                 |                       |                                |                         | rince        |            |                                    |                     |
| Ħ          | Funeral   |                  | ,  | Sex 7. Ag<br>1 ☐ M XXX F  | e (In yrs. last birth          | day) If Under 1 Months E                   | Year If Und<br>Days Hour        | ler 24 Hrs.<br>s Min. | 8. Date of Bi<br>(Month, D     | ay, Yea                 | r)           | Count      | try)                               | e or Foreign        |
|            | Director  |                  | 578 15 5316 Usual Residence of Decedent  | 7111  | 34                             |  |                                 |                       | NOV. 2                         | 5, ]                    | 1973 I       | PUERT      | O RI                               | <u>CO</u>           |
|            | yland<br>iow<br>at  |                  | 10a. State 10b. County   |   | 10c. City, Town                | or Location                                |                                 |                       |                                |                         |              | 10         |                                    | City Limits         |
|            | a-fsh   | cto              | MD PRINCE (  | GEORGES   | BOWIE                          |  |                                 |                       |                                |                         |              |            | X1X Y                              | es 2 No             |
|            | ith the   | Director         | 10e. Street and Number   |   |                                | 10f. Zip C                                 |                                 |                       |                                |                         | itizen of WI |            | •                                  |                     |
|            | ath w   | lal              | 2206 BERMONDSEY  |   |                                | 207  |                                 |                       |                                |                         | ITED         |            |                                    |                     |
| 36         | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23a or 28a-f show<br>he Medical Examiner must be notified at                    | by Funeral       | 11. Marital Status  XX Never Married 2  Married 3  Widowed 4  Divorced                             | 12. Was Decedent<br>Armed Forces?<br>1 ☐ Yes ※ ★ If Yes, Give<br>Year or Dates: |                                | 13. Was Deceder If Yes, specify 1 ☐ Yes XX |                                 |                       | ecity Yes of N<br>Rican, etc.) | 0-                      | Black        | , White, e | etc.                               |                     |
| 8          | tural   | edt              | 15. Decedent's 8   |   | 16a. [                         | Decedent's Usual (                         | Occupation                      |                       |                                | 16b.                    | Kind of Bus  | siness/Ind | lustry                             |                     |
| 21215-0036 | in 72<br>in "na<br>Medic  | Completed        | (Specify only highest g  | rade completed) College (1-4or 5  | 5+)                            | Give kind of work<br>life. DO NOT use      | done during n<br>retired)       | nost of work          | ing                            | 1                       |              |            |                                    |                     |
| 212        | filed withir<br>Hygiene.<br>rther than<br>int, the Me   | ĕ                |  | 4+  |                                | UNEMPLOY                                   |                                 |                       |                                |                         | NON          |            |                                    |                     |
| nd         | be filed within 72 hartal Hygiene. d other than "natuevent, the Medical   | Be (             | 17. Father's Name (First, Middle, Las  | st)   |                                |  |                                 |                       | (First, Middle                 |                         |              | )          |                                    |                     |
| Z          | should be tand Mental Is marked of umatic eve   | မှ               | JAMES TURNBULL  19a. Informant's Name/Relationship   | (Time Print)  | 10h                            | Mailing Address (5                         |                                 |                       | NE BELS                        |                         |              | Stata Zin  | Codal                              |                     |
| Maryland   | d 2 th 3  |                  |  |   |                                | 01 GILBRA                                  |                                 |                       | BOWIE,                         |                         |              | nare, zip  | Code)                              |                     |
|            | is 1 and<br>of Health<br>Item 27<br>other to  | -                | JAYRELLE ISRAEL 20a. Method of Disposition   | / SISTER  | 20b. Place of I                | Disposition (Name<br>crematory or other    | of                              | 1                     | Date 5                         | _                       | Location - C | City or To | wn, State                          |                     |
| E O        | Pages<br>nent of h<br>int: if ite   |                  | XXBurial 2 □Cremation 3<br>4 □Donation 5 □ Other (Spec   |   | 1                              | N CEMETE                                   | , ,                             | 02-08                 | -2008                          | ST                      | r. THO       | MAS.       | VT                                 |                     |
| Baltimore, | permit. Pages<br>Department of<br>Important: If I<br>any injury or<br>once.   |                  | 21. Signature of Funeral Service Lic   | D. CRAY   | NEDIEIL                        | 22. Name and MARSHAL                       | Address of Fa<br>L S FU         | cility<br>NERAL       | HOME (                         | )F M                    | ARYLA        | ND,        | INC.                               |                     |
|            | 80 = e 0  |                  | 23a Part Enter the disease of CO   | /   | the death Do no                | 4308 SU                                    |                                 |                       |                                |                         | , MD         | 2074       |                                    | nate                |
|            | Dhaalalaa   |                  | 23a. Par 1. Enter the disease, or co<br>shock, or heart failure. List on<br>Immediate Cause (Final | y one cause on each li  | ne.                            |  |                                 |                       |                                |                         |              |            | Approxim<br>Interval E<br>Onset an | Between<br>ad Death |
|            | Physician /Medical  |                  | disease or condition resulting in death)   |   | OIAL INFA<br>a consequence of  |  |                                 |                       |                                |                         |              |            |                                    |                     |
|            | Examiner  |                  |  | b DIABETI   | ES                             |  |                                 |                       |                                |                         |              |            |                                    |                     |
|            | p #   | ner              | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury                     | Due to (or as   | a conse juence o               | )s   |                                 |                       |                                |                         |              | - 1        |                                    |                     |
|            | ecute<br>and<br>trans   | Examiner         | that initiated events resulting in death) Last   | U   | AGE RENAI a consequence of     |  |                                 |                       |                                |                         |              |            |                                    |                     |
| 68760,     | be exician  |                  |  |   | a consequence o                | <i>J</i> •                                 |                                 |                       |                                |                         |              |            |                                    |                     |
| 587        | ficate<br>phys<br>s the   | odic             |  | d   |                                |  |                                 |                       |                                |                         |              |            |                                    |                     |
| Box (      | The law requires that the death certificate be executed tables been signed by the attending physician and tage 2 should be detached for use as the burial-transit | Physician/Medica | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome  | pf pregnancy<br>2  Fetal death | 3 □Ectopic preg                            | nancy                           |                       |                                |                         | 23d. Date    |            | ,                                  |                     |
|            | ne deal<br>the att  | sicis            | in the past 12 months?<br>1 ☐ Yes XX No<br>9 ☐ Unknown   | 4☐Pregnant a<br>9☐Unknown   |                                | 5 ☐ Other (spec                            |                                 |                       |                                |                         | Mon          | ith        | Day                                | Year                |
| P.0        | that the de   |                  | Part II. Other significant conditions  | contributing to death b   | out not resulting in           | the underlying cau                         | se given in Pa                  | art I.                | 23e. Did                       | tobacco                 | use contri   | bute to th | ne cause o                         | of death?           |
| Records,   | w requires<br>been signe<br>should be   | d by             |  |   |                                |  |                                 |                       | 1                              | ] Yes                   | XX No        | 3 ☐ Prob   | ably 4 [                           | Unknown             |
| 000        | aw rec<br>s bee   | Completed        |  |   |                                |  |                                 |                       | 24a. Wa                        |                         | 24b. W       | ere auto   | psy finding                        | gs available        |
|            | <b>hysician:</b> The law<br>his certificate has t<br>I director, page 2 s   | mo               |  |   |                                |  |                                 |                       | per                            | opsy<br>formed?<br>27 N | de de        | eath?      | npietion o                         | if cause of         |
| İta        | stan:<br>ertifica<br>ctor, I  | Be C             | 25. Was case referred to medical examiner?   |   |                                |  |                                 | ace of Deat           | h (Check only                  |                         |              |            |                                    |                     |
| or Vital   | Physician:<br>this certific<br>ral director,  | 10               | 1X Yes 2 No  | Hospital: 1 Inpatie   | 2323                           |  |                                 | Nursing Ho            | ome 5 Res                      |                         |              |            | y)                                 |                     |
| n C        | Ing<br>After  | ion:             | 27. Manner of Death  1 X Natural 5 □ Pending   | 28a. Date of Inju<br>(Month, Da   | ury 28b. Ti<br>ny Year) In     | jury M                                     | lnjury at<br>Work?<br>1 ☐ Yes 2 | P I No                | 28d. Describe                  | how in                  | jury occurre | ed         |                                    |                     |
| Division   | death<br>death<br>ctor:<br>y the  | Certification:   | 2 Accident investigati 3 Suicide 6 Could not   | be 28e. Place of ini  | ury - At home, far             |  |                                 |                       | 28f. Location                  |                         |              | er or Rura | l Route N                          | lumber,             |
| Ω          |   | ertil            | 4 ☐ Homicide determine   | building, e   | tc. (Specify)                  |  |                                 |                       | City or To                     | own, Sta                | ate)         |            |                                    |                     |
|            | To the Hospital or A<br>within 24 hours after<br>To the Funeral Dire  | Medical C        |  | Physician: To the best<br>aminer: On the basis of<br>and manner st              | of examination and             |  |                                 |                       |                                |                         |              |            |                                    | e(s)                |
|            | within To the To the Comple   | Me               | 29b. Signature and title of certifier  |   | -                              | 29c. I                                     | icense numb                     | er                    |                                | 29d. E                  | Date signed  | (Month,    | Day, Year                          | 7)                  |
|            | 18  |                  | I doubt  | on- MD  |                                |  | MD3118                          | 32                    |                                | 01                      | -31-2        | 800        |                                    |                     |
|            | 000   |                  | 30. Name and address of person wh  | o completed cause of  |                                |  |                                 |                       | 1                              |                         |              |            |                                    |                     |
|            | B(C)  |                  | JOYCE M. GONIN,  |   |                                | OWN UNIVI                                  | ERSITY                          | HOSPI                 | TAL                            | WAS                     | HINGT        | ON,        | DC 20                              | 0002                |
|            | Sta<br>Regist   |                  | FEB 0 1 2008 (ear)   | 32. Regist  | rar's Signature                | •  |                                 |                       |                                |                         |              |            |                                    |                     |

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** TOBIAS JAN MYRTICE 26 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOWARD ELLICOTT CITY MORNINGSIDE HOUSE Birthplace (State or Foreign Country) If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year) Hours Min. 1 M 2 X F Halls Hill, VA. Director 91 578-62-2286 Nov. 25, 1916 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notifled at xt⊠Yes 2 No Director Howard Maryland Elliott 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 5330 Dorsey Hall Drive 21041 Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2K No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. BLACK Š 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene. 7 Is marked other than "ne College (1-4or 5+) Elementary/Secondary (0-12) D.C. GOVERNMENT TEACHER +6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **ODESSA** SMITH ပ ASA ROBINSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11375 Heathertoe Lane Columbia, Maryland 21044 Beverly White-Seals/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Important: If iten
any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/31/2008 Brentwood Fort Lincoln Memorial 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. uneral Service License 5538 Marlboro Pike Forestville, Maryland 20747 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final Vascular disease Atheroscherotic **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Fibrilla tion 24a. Was an page 2 performed Yes 2 2 1 No or Attending Physician: director, 25. Was case referred to medical 26. Place of Death Check onl one Medical Certification: To Be Hospitat: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 ☐ Pending investigation 1 Natural Injury s after dea... ral Director: Aftr 1 Tyes 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P-53636 28, 2008 ARCSON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10100 charter Prive Columbia Mp 21044 KEVIN BISHOFF CARISON, MP 32. Registrar's Signa 31. Date filed (Month, Day, Year) State FEB 0 1 2008

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Deatl **Physician** 26, 2008 Mae Thomas January 0305 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges' Community Hospital Cheverly PG 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F 12/25/1919 Months Days Hours Min 252-32-9060 88 Georgia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f shoved at Examiner must be notified at Capital Heights MD PG 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 1213 Boones Hill Road U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 NWidowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Chear 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked o Will Maddox Donsey (Unknown) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1213 Boones Hill Road #1; Capital Heights, MD 20743 item 27 i Dorothy M. Ball - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Memorial Cemetery 2/5/2008 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If Its any Injury or o 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donațien 5 □ Other (Specify) Suitland, Maryland 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licensee 4549 Beech Road; Temple Hills, MD 20748 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, aus on each line. Approximate Interval Betweer Onselyand Deatl 23a. Parit. Enter the disease, or complice shoot, and heart failure. List only one Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as d consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Inknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 29a. Certifier 🛮 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 16,2008 lanuar address of person who completed cause of death (Item 23a) (Type, Print) Kras VINCE 32. Registrar's Signature 31. Date filed (Month. Day, Year) State 2008 JAN 3\_1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Eugene Williams 29, 2008 21:52 January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 X M 2 □ F 439-32-7741 77 June 5, 1930 Texas Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2/□No Maryland St. Mary's Charlotte Hall 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 29449 Charlotte Hall Road 20622 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Staff Sergeant U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Eugene Williams Mahle Samue1s 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Schneider/Daughter Geothestrasse 6, Berlin, Germany 10623 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Brinsfield-Echols Cr. 2/2/2008 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A.
30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

burial-tran Division or Vital Records, P.O. Box 68760 attending physician SMPILIONS

After death 0 To the Hospital of within 24 hours af To the Funeral D

**Physician** 

/Medical

Examiner

Director

Funeral

Completed

Be

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Examine

Physician/Medical

2

Completed

Be

Certification: To

Medical

1 Natural

2 Accident 3 Suicide

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore.

d 2 should be filed w th and Mental Hygies 7 is marked other th

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, i

**Physician** /Medical

Examiner

State Registrar

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avani Shah

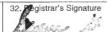
5 Pending investigation

6 Could not be determined

Leonardtown, Maryland 20650

1 ☐ Yes 2 ☐ No

31. Date filed (Month, Day, Year) 2008 FFR 1 1



and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene

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State

Registrar

FEB 0 6 2008

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State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 1

2008

32. Registrar's Signature

|                   |  |                | riease i   | State of Maryland / D   |                 |   |  |   | _                       | lible.                          |                                       |
|-------------------|--|----------------|--|---|-----------------|---|--|---|-------------------------|---------------------------------|---------------------------------------|
|                   |  | •              | For<br>State<br>Registrar  | _   |                 | tificate of i   |  |   | Reg. No.                | 08                              | 04367                                 |
| N.                | A - 3  |                | Decedent's Name (First, Middle, Last)  | 1   | - 1             |   |  | 2. Date of De.                          | ath                     | V                               | 3. Time of Death                      |
|                   | Physicia<br>/Medic   | 3              | Helen  | \   | W               | arne  | ~  | Jan                                     | 30 2                    | 008                             | 1:00 a M                              |
|                   | Examin   | in a           | 4a. Facility Name (If not institution, give                                      | street and number)  |                 | 4b. City, Town, or  | r Location of Death                                  |   | 4c. Coun                | ty of Death                     |                                       |
|                   |  | i e            | Washington Advent  |   |                 | Takoma  |  | 0 Day (B)                               |                         | gomer                           | 4                                     |
| (Also             | Funeral Director   |                | 5. Social Security Number 6. Security 8393-52-6222                               | 3.4. OFF) =   | rs.             | Months Days   | Hours Min.   | 8. Date of Bird<br>(Month, Da<br>Apr 18 | y, Year)<br>1914        |                                 | place (State or Foreign<br>ntry)      |
|                   | -  |                | Usual Residence of Decedent  | 93  |                 |   |  | Apr 10                                  | 1714                    | ⊥ W1S                           | consin                                |
|                   | arylan   | ٠.             | 10a. State 10b. County   | 10c. City, Town   | or Loc          | cation  |  |   |                         | 1                               | 10d. Inside City Limits 1 ☐ Yes 2X No |
|                   | Ba-f   | Director       | MD Prince G  | eorges Hyatts   | vil             |   |  |   | 10- China a             | 4 14/5 - 4 C                    |                                       |
|                   | with t   |                | 10e. Street and Number   | 1 0.1   |                 | 10f. Zip Code   | 0.702  |   | 10g. Citizen of USA     | what Cour                       | itry ?                                |
|                   | Jeath<br>ms 23   | Funeral        | 5805 Queens Chape  | 12. Was Decedent Ever in U.S.                                   | 13. V           |   | 20782<br>Iispanic Origin? (Sp<br>an, Mexican, Puerto | ecify Yes or No                         |                         | ace - Americ                    |                                       |
| 9                 | atter o  | Fur            | 1 X Never Married 2 ☐ Married  | Armed Forces?<br>1 ☐ Yes 2 ☒ No<br>If Yes, Give                 | 1               | Yes, specify Cuba   |  | Rican, etc.)                            |                         | ack, White,                     | etc.                                  |
| 21215-0036        | d within 72 hours atter death with the Maryland<br>piene.<br>rr than "natural", or Itams 23a or 28a-f ahow<br>tra Medical Exantraer mat be notified at | d by           | 3 Widowed 4 Divorced   | Year or Dates:  | <u> </u>        | LI TES ALKINO   | Specify:   |   | Spec                    | Wh                              | ite                                   |
| 15-               | natu<br>odica  | Completed      | 15. Decedent's Edu<br>(Specify only highest grad                                 | e completed)  | (Give I         | ent's Usual Occup<br>kind of work done of<br>OO NOT use retired | durina most of work                                  | in <b>g</b>                             | 16b. Kind of            | Business/In                     | dustry                                |
| 12                | within<br>lene.<br>then  | dwo            | Elementary/Secondary (0-12)<br>8th   | College (1-4or 5+)  |                 | isabled   | -/   |   | N                       | one                             |                                       |
|                   | 事等で  | Be C           | 17. Father's Name (First, Middle, Last)  |   |                 |   | 18. Mother's Nam                                     | e (First, Middle,                       |                         |                                 |                                       |
| ılar              | Mental<br>Mental<br>rked o   | To B           | Joseph Warner  |   |                 |   | Mary   | Naujak                                  |                         |                                 |                                       |
| Maryland          | s 1 and 2 should<br>f Health and Men<br>Item 27 Is marke<br>other traumatic  |                | 19a. Informant's Name/Relationship (Ty   | rpe, Print) 19b.  | Mailin          | g Address (Street   | and Number or Rui                                    | al Route Numbe                          | er, City or Tow         | n, State, Zip                   | ) Code)                               |
|                   | 1 and<br>Health<br>em 27<br>ther tr  |                | Jeanette Honsa/Rep   |   |                 | onifant State of  |  | er Spri                                 |                         |                                 |                                       |
| Baltimore,        | permit. Pages 1 an<br>Department of Heal<br>Important: If Item 2<br>any injury or other<br>once.   |                | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F                        | Removal from State  | v, crem         | natory or other place   | ре)  |   | 20c. Location           | 1 - City or 10                  | own, State                            |
| Ħ                 | it. Pa   | i              | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens        |   |                 | PK Crema  | atory 1-3  | 1-2008                                  | River                   | dale,                           | MD.                                   |
| Ba                | permit.<br>Departi<br>Importi<br>any inj<br>once.  |                | In Shaun L   | Chetta  | N               | Murray Fu   | meral HO   | me                                      | shingto                 | n DC                            | 20011                                 |
|                   |  |                | 23a. Part1. Enter the disease, or compl<br>shock, or heart failure. List only or | ications that caused the death. Do no                           |                 |   |  |   |                         | 11, 100                         | Approximate<br>Interval Between       |
| ri.               | Physician  |                | Immediate Cause (Final disease or condition                                      | 5 01-0 4  |                 |   |  |   |                         |                                 | Onset and Death                       |
|                   | /Medical   |                | resulting in death)  | Due to (or as a consequence or                                  | of):            |   |  |   |                         |                                 |                                       |
| 3                 | Examiner   |                | Sequentially list conditions,  | lyangres  | ne              | Lebt  | 6001   |   |                         |                                 |                                       |
|                   | ed isit  | line           | if any, Isading to immediate cause. Enter Underlying Cause (Disease or injury    | Dife to (or as a co (equence of                                 | et):<br>مرا الم | 2~  | V  |   |                         |                                 |                                       |
|                   | be executed<br>iician and<br>burial-transit  | Examiner       |  | Due to s a consequence of                                       | of):            | 70)   | ۸ .  |   |                         | -                               |                                       |
| 760,              | te be executed<br>ysician and<br>he burial-transit   | caiE           |  | , Periple al  | 1               | Vascu   | lar di   | 5 6                                     | e "                     |                                 |                                       |
| 9                 | leath certiticate t<br>attending physi   | ledic          |  |   |                 |   |  |   |                         |                                 |                                       |
| Вох               | death certitical<br>e attending phy<br>d for use as th   | Physician/Medi | 23b. Was decedent pregnant   | 3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death | 3 🗆             | Ectopic pregnancy   | ,  |   | 1                       | Date of deliver                 | ery<br>Day Year                       |
| 0                 | 0 0 0  | /sici          | in the past 12 months?<br>1 ☐ Yes 2 ② No<br>9 ☐ Unknown                          | 4☐Pregnant at time of death<br>9☐Unknown                        | 5 🗆             | Other (specify)   |  |   |                         | TOTAL                           | Day Tour                              |
| <u> </u>          | requires that the d<br>een signed by the<br>hould be detached  |                | Part II. Other significant conditions cor  | ntributing to death but not resulting in                        | the un          | nderlving cause giv   | ren in Part I.                                       | 23e. Did t                              | obacco use co           | ntribute to t                   | the cause of death?                   |
| ds,               | es un es   | d by           |  |   |                 | , , ,   |  | 10                                      | Yes 2 🔼 No              | 3 ☐ Prol                        | bably 4 Unknown                       |
| CO                | > - 0  | ompieted       |  |   |                 |   |  | 24a. Was                                | an 24b                  | . Were auto                     | opsy findings available               |
| Re                | 9 4 9  | omp            |  |   |                 |   |  |   | osy<br>ormed?<br>2 🔯 No | prior to co<br>death?<br>1  Yes | impletion of cause of                 |
| ital              | ician: Th<br>certificate<br>rector, pag  | O              | 25. Was case referred to medical   |   |                 |   | 26. Place of Dea                                     |   |                         | 1 1 1 1 1 1 1 1 1               | 2010                                  |
| of Vital Records, | S S D  | To B           | examiner?<br>1 ☐ Yes 2 ဩ No  | lospital: 1 XInpatient 2 ☐ ER/Out                               | patient         | t 3 DOA Oth   | ier: 4 ☐ Nursing H                                   | ome 5 Resi                              | dence 6 □0              | ther (Speci                     | fy)                                   |
| n c               | ding Ph.<br>h.<br>After th<br>funeral  | iuo!           | 27. Manner of Death<br>1 ⊠Natural 5 ☐ Pending                                    | 28a. Date of Injury 28b. Ti                                     | ime of<br>njury | 28c. Injur<br>Wor   |  | 28d. Describe                           | how injury occi         | urred                           |                                       |
| Division          | Attending<br>r death.<br>ector: After<br>by the fune   | Certification; | 2 Accident investigation 3 Suicide 6 Could not be                                | 28e. Place of Injury - At home, fare                            | m etre          |   | Yes 2 □No  | 28f Location (                          | Street and Nun          | nher or Rur                     | al Route Number,                      |
| Ď                 | i Dirte  | ertif          | 4 Homicide determined  | building, etc. (Specify)  | m, and          | set, factory, office  |  | City or To                              |                         | 1507 07 71576                   | 177 TODIO TAGINDOT,                   |
|                   | Hospital<br>24 hours a<br>Funeral I  |                |  | sician: To the best of my knowledge,                            |                 |   |  |   |                         |                                 |                                       |
|                   | he Hos<br>in 24 ho<br>he Fun<br>pletely  | edicai         | (Check only 2 Medical Exami  | ner: On the basis of examination and<br>and manner stated.      | Vor inv         | restigation, in my o  | ppinion, death occur                                 | red at the time,                        | date and place          | and due to                      | o the cause(s)                        |
|                   | To the within 2 To the complet   | Σ              | 29b. Signature and title of certifier  |   |                 | 29c. Licens   | se number  |   | 29d. Date sign          | ied (Month,                     | Day, Year)                            |
| À                 | 1  |                | 1 Clad   | ma MD   |                 | D63   | 3839   |   | 1/30                    | 30/08                           | 2 .                                   |
| 2                 | (4)  |                | 30. Name and address of person who co  | ompleted cause of death (Item 23a) (1<br>illa, MD. 7600 Ca      |                 |   | Takoma Pa  | ark. MD                                 | 20912                   | 1                               |                                       |
| 205               | Sta  | te.            | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signature                                       |                 | 1110  | I GIOING I C   | -11, 110                                |                         |                                 |                                       |
| 4                 | Registr  |                | FEB 0 1 2008   | 32. Registrar's Signature                                       | 0               |   |  |   |                         |                                 |                                       |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** FEBRUARY 10 2008 E6-6 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BAYVIEW MEDICAL CENTER Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🙀 F 75 212-28-5348 July 17,1932 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be provided. 10d. Inside City Limits 10c. City. Town or Location 10a. State 1 □Yes 2 No Dundalk Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21222 7341 Manchester Road Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married & Married 1 ☐ Yes 2X No Specify. Specify: Baltimore, Maryland 21215-0036 White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) <u>Health Care Provider</u> Nurse Vears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Appler ဥ John Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sterling, VA 47063 Garrett Place 20165 Patrice DeHaven (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, MD MXBurial 2 ☐ Cremation 3 ☐Removal from State 2/14/2008 Moreland Mem. Park Cem. 4 Denation 5 ☐ Other (Specify) 21. Signatur 22. Name and Address of Facility Funeral Service License Duda-Ruck Funeral Home of Dundalk, Inc. 00 21222 Dundalk, Maryland 7922 Wise Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): hours **Physician** /Medical **Examiner** Mouths Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-trar and Due to (or as a consequence Box 68760, attending physician Physician/Medical as the IF FEMALE: use 8 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐Unknown signed by ta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Innknown PERCALCEMIA Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No RENAL FAILURE 24a. Was an page 2 s 1□ Yes Division or Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 No 2 ER/Outpatient 3 DOA 1 TYes ဥ After this 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28a Date of Injury 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. spital or Attendi nours after death. neral Director: A 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 4 Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 10,2008 000 MD

State Registrar 30. Nam

JASON

B.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

EASTERN AVENUE, BALTIMORE, MD

and address of person who completed cause of death (Item 23a) (Type, Print)

MD

WILLIAMS

4940

32 Registrar's Signature

|  | 1 - For State Registrar  1. Decedent's                             | Name (First, Midd                            |  |  | -                              | rtificate of                                   |                          | 2. Da        | Reg.                               | No. 20                        |   | me of Death                      |
|--|--|--|--|--|--------------------------------|--|--------------------------|--------------|------------------------------------|-------------------------------|---|----------------------------------|
| hysician/<br>Medical/  | DONA   | LD WAYNE                                     | ALPHIN   |  |                                |  |                          |              |                                    | Day <b>200</b>                | Year 21                                     | :20 P                            |
| Examiner   | 4a. Facility Na  | me (If not institutio                        | n, give street and nur                                 | mber)  |                                | 4b. City, Town, o                              | r Location of D          | eath         |                                    | 4c. County of                 | f Death                                     |                                  |
|  | UNION<br>5. Social Secu  | HOSPITAL                                     | 6. Sex   | 7. Age (In yrs.  | la at hirthday                 | ELKTO  |                          | Hrs   9 Do   | te of Birth                        | CECI                          |   | W-1 51-                          |
| uneral<br>rector   | 242-24   |  | 1 <b>X</b> M 2□F                                       | 86   | Yrs.                           | Months Days                                    |                          | Vin. (Mo     | onth, Day, Ye<br>3/1921            | ar)                           | 9. Birthplace (\$ Country)                  | NC                               |
| at   | 10a. State   | 10b. County                                  | 1  | 10c. City  | , Town or Lo                   | ocation  |                          |              |                                    |                               | 10d. Ins                                    | ide City Limits                  |
| tor  | MD   | CEC  | IL   | EA   | RLEVII                         | LLE  |                          |              |                                    |                               | 10  | ]Yes 2. XXNo                     |
| Dire   | 10e. Street an   |  |  |  |                                | 10f. Zip Code                                  |                          |              | 10g.                               | Citizen of Wh                 | nat Country?                                |                                  |
| other traumatic event, the Medical Examiner must be notified at  To Be Completed by Funeral Director | 792B K   | NIGHT IS                                     |  | dest Free is II  | 0 140                          | 2191   |                          | 0.40         |                                    | USA<br>14 Page                | - American Indi                             | 20                               |
| Funeral Director   | 11. Marital Sta  | itus<br>Married 2∐ Mai                       | Armed Fo   | edent Ever in U.<br>rces?<br>2 □ No  | 5. 15.                         | Was Decedent of I<br>If Yes, specify Cub       | an, Mexican, P           | uerto Rican, | etc.)                              |                               | White, etc.                                 | an,                              |
| ۵  | 3 🙀 Widov  | ved 4 Divorced                               | I It Yes, Giv  | /e   | ı                              | 1 □ Yes 2 👿 No                                 | Specify:                 |              |                                    | Specify:                      | WHITE                                       | :                                |
| Completed  |  | 15. Deceder                                  | nt's Education<br>est grade completed)                 |  | (Give                          | dent's Usual Occup                             | during most of           | workina      | 16b                                | . Kind of Busi                | iness/Industry                              |                                  |
| a la   | Elementary   | Secondary (0-12)                             | College (1   |  | `life.                         | DO NOT use retire                              | d)                       |              |                                    |                               |   |                                  |
| ပိ   |  | . 1<br>ame ( <i>First, Middle</i>            | 3.5  | •  | OWN                            | EK   | 18. Mother's             | Name (First. |                                    | IOTEL<br>fen Surname          | )   |                                  |
| To Be  |  | H. ALPH                                      | ,  |  |                                |  |                          | LYLE         | •                                  |                               | ,   |                                  |
| -  |  | t's Name/Relations                           |  |  | 19b. Mailir                    | ng Address (Street                             |                          |              |                                    | ty or Town, S                 | tate, Zip Code)                             |                                  |
|  | TODD A   | LPHIN/SO                                     | N  |  | 792 F                          | NIGHT IS                                       | LAND_RD                  | . EAR        | LEVILL                             | E, MD                         | 21919                                       |                                  |
| once,  | 20a. Method o  |  | 3 ☐Removal from  | 1 6  | lace of Dispo<br>emetery, crei | osition (Name of<br>matory or other pla        | ce)                      | Date         | 20c                                | Location - C                  | ity or Town, St                             | ate                              |
|  | 4 □ Dona   | tion 5 ☐ Other (                             | Specify)   | 1  |                                | E CREMAT                                       |                          | 5/200        | 8 S                                | TEVENS                        | VILLE,                                      | MD                               |
|  | 21. Signature  | of Funeral Service                           | Licensee   |  | FF                             | 2. Name and Addre                              | ess of Facility  ELFENBE | EIN & I      | NEWNAM                             | FUNER                         | AL HOME                                     | . PA                             |
|  | 23a, Part1, E  | eter the disease of                          | r complications that c                                 | aucad the death  |                                | <u> 6 E. MAI</u>                               | N ST. C                  | ECILTO       | ON, MD                             | 21913                         |   | eximate                          |
| Ŋ.   | Shock, o   | r heart failure. Lis                         | t only one cause on e                                  | ach line.  |                                | -  |                          |              | latory allest,                     |                               | Interv                                      | al Between<br>t and Death        |
| 1  | disease or co<br>resulting in de                                   | ndition                                      | a  | or as a consequ  | lenge of):                     | CW   | VIII                     |              |                                    |                               |   |                                  |
| er   |  |  |  | 5/   | slew                           | c co   | WPNA                     | e            |                                    |                               |   |                                  |
| ner  | Sequentially li<br>if any, leading<br>cause. Enter<br>Cause (Disea | st conditions,<br>to immediate<br>Underlying | Due to (   | or as a consequ  | ence of):                      |  |                          |              |                                    |                               |   |                                  |
| Examiner   | Cause (Diseas<br>that initiated e<br>resulting in de               | vents  | c  |  |                                |  |                          |              |                                    |                               |   |                                  |
|  |  | an, 2331                                     | Due to (   | or as a consequ  | ience or):                     |  |                          |              |                                    |                               |   |                                  |
| Medical  |  |  | d  |  |                                |  |                          |              |                                    |                               |   |                                  |
| No.  | IF FEMALE:<br>23b. Was dec   | edent pregnant                               |  | come of pregna   |                                | Je   |                          |              |                                    | 23d. Date                     | of delivery                                 |                                  |
| icia   | in the pa<br>1 ☐ Yes   | st 12 months?<br>2 ☐ No                      | 4□Pregn  | irth 2□Feta<br>ant at time of d  |                                | ∃Ectopic pregnanc<br>∃Other <i>(specify)</i> _ | y                        |              |                                    | Mont                          | th Day                                      | Year                             |
| Physician/I  | 9 ☐ Unki   |  | 9□Unkno  |  |                                |  |                          |              |                                    |                               |   |                                  |
| þ  | Part II. Other s   | significant conditi<br>()                    | ons contributing to de                                 | eath but not resu  | Itting in the u                | nderlying cause giv<br>مدادا                   | ven in Part I.<br>∿v     | 23           |                                    |                               | oute to the caus                            |                                  |
| ted  |  |  | 0101010  | 1 (45  | 1000                           | 11   |                          | -  -         | ı ⊔ res                            | 2[] NO 3                      | B ☐ Probably                                | 4 Unknown                        |
| Completed  |  |  |  |  |                                |  |                          | 24           | la. Was an<br>autopsy<br>performed | pri                           | ere autopsy fin<br>ior to completio<br>ath? | dings available<br>n of cause of |
|  |  | referred to medica                           | u T  |  |                                |  |                          |              | Yes 2                              |                               | Yes 2□N                                     | 0                                |
| o Be   | examiner?  | referred to medica<br>2 No                   | Hospital:  | npatient 2   | ER/Outpatier                   | nt 3 DOA Oth                                   | 26. Place of ler:        |              |                                    |                               | /Oif-/\                                     |                                  |
| n: To  | 27. Manner of  | Death  | 28a. Date  | of Injury  | 28b. Time o                    |  |                          |              |                                    | 6 Other                       |   |                                  |
| atio   | 1 X Natura<br>2 ☐ Accide   |  | ig .   | th, Day Year)  | Injury                         |  | Yes 2 No                 |              |                                    |                               |   |                                  |
| Certification:   | 3 ☐ Suicio<br>4 ☐ Homio  |  | Zoe, Flace   | of injury - At ho  | me, farm, str                  | eet, factory, office                           |                          | 28f. Loc     | cation (Street<br>ty or Town, St   | and Number                    | or Rural Route                              | Number,                          |
| Çe   |  |  |  |  |                                |  |                          |              |                                    |                               |   |                                  |
| Medical  | 29a. Certifier<br>(Check on<br>one)                                | 1 & Certifyi<br>2 ☐ Medical                  | ng Physician: To the<br>Examiner: On the ba<br>and man |  |                                |  |                          |              |                                    | e(s) and man<br>and place, ar | ner as stated.<br>nd due to the ca          | ause(s)                          |
| Ž  | 29b. Signatur  | and title of certifie                        | MA   |  |                                | 29c. Licens                                    | e number                 |              | 29d.                               | Date signed                   | (Month, Day, Y                              | ear                              |
|  |  | M  | 1  |  |                                | DS   | 1180                     |              |                                    | Jam 3                         | Month, Day, Y                               | U                                |
|  | 30. Name and   | address of person                            | who ompleted caus                                      | e of death (Item   | 23a) (Type,                    | Print)   | ARTON                    | linh         | 106                                | BUW                           | MS 2  | 27                               |
| State  | 31. Date filed   | (Month, Day, Year,                           |  | egis ar s Signa  | ture                           | 1.0.   |                          |              |                                    |                               |   |                                  |
| gistrar  |  | FEB  | 0 5 2008   | De la constante de la constant | JOB 4                          |  |                          |              |                                    |                               |   |                                  |
| ev 1/2001  |  |  |  |  |                                | •  |                          |              |                                    |                               |   |                                  |

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**Physician** 

/Medical

Examiner

**Funeral** 

Director

Baltimore, Maryland 21215-0036

| land  |                   | 10a. State  | 10b. County                                    |  | 10c. City, To         | own or Loca                          | ition                                     |  |                             |                           |                                | 10d. Inside City Limits                            |  |
|---|-------------------|---|--|--|-----------------------|--------------------------------------|---|--|-----------------------------|---------------------------|--------------------------------|--|--|
| Mary  | ō                 | MD  | n/a  |  | Bal                   | timor                                | e City                                    |  |                             |                           |                                | 1⊠Yes 2□No   |  |
| the the   | Director          | 10e. Street and Nun   |  |  | חסו                   | CTINOL                               | 10f. Zip Co                               |  |                             | 10g. C                    | itizen of What Co              | untry?   |  |
| or death with the Maryla<br>terns 23a or 28a-f shov<br>ar must be notified at   | ā                 |   | oston Stre                                     | e+ # 601                                       |                       |                                      |   | 1224   |                             | _                         | USA                            | ,  |  |
| eath  | Funeral           | 11. Marital Status  | 33 0011 3 010                                  | 12. Was Decedent                               | Ever in U.S.          | 13. Wa                               |   | of Hispanic Origin? (5                           | Specify Yes or N            |                           | 14. Race - Ame                 | ncan Indian,                                       |  |
| Iten d  | 'n                |   | ied 2 ☐ Married                                | Armed Forces?<br>1 ☐ Yes 2 📉                   |                       | lf Y                                 | es, specify                               | Cuban, Mexican, Puer                             | to Rican, etc.)             | _                         | Black, White                   |  |  |
| al', or   | by                | 3 💢 Widowed   | _  | If Yes, Give<br>Year or Dates:                 |                       | 10                                   | ∐Yes 2X                                   | No Specify:                                      |                             |                           | Specify:                       | White  |  |
| is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other transmission ovent. The Medical Evantisis runs Lie, notified at | Completed         | (Speci  | 15. Decedent's Editify only highest grad       |  |                       | 6a. Deceder<br>(Give kii<br>life. DC | nt's Usual O<br>nd of work o<br>NOT use r | lone during most of wo                           | rking                       | 16b.                      | 16b. Kind of Business/Industry |  |  |
| d with<br>giene<br>er tha   | mo;               | Elementary/3ecol  | ildaly (0-12)                                  | 2  | ,+)                   | Hom                                  | emake:                                    | r  |                             |                           | Dwn                            | Home   |  |
| t be file<br>intal Hy<br>ed oth   | Be                | 17. Father's Name (   |  | nis  |                       |                                      |   | 18. Mother's Na.                                 |                             | e, Maide<br>Cman          | n Sumame)                      |  |  |
| s 1 and 2 should<br>f Health and Men<br>fem 27 is marke<br>other traumatic  | 2                 |   | ame/Relationship (T)                           |  | 1                     | 19b. Mailing                         | Address (SI                               | treet and Number or Ri                           |                             |                           | or Town, State, Z              | lip Code)  |  |
| Ith ar<br>Ith ar<br>27 Is   |                   | Peter Ada   |  |  |                       |                                      |   |  | Apt. 309                    |                           | altimore                       |  |  |
| Hea<br>Hea<br>tem<br>othe   |                   | 20a. Method of Disp   |  |  | 20b. Place            | of Disposit                          | ion (Name                                 | of   | Date Date                   |                           | Location - City or             |  |  |
| permit. Pages 1<br>Department of +<br>Important: If Ite<br>any injury or ot<br>once.  |                   |   | ☐ Cremation 3 ☐ I<br>5 ☐ Other (Specify)       |  |                       | etery, crema<br>ngton                |   | Cemetery O                                       | 2/20/08                     | Ar                        | lington,                       | VA   |  |
| rmit.<br>spartn<br>ports<br>y inju  |                   | 21. Signature of Fu   | neral Service Licens                           | see //   |                       |                                      |   |  |                             |                           |                                | Home, Inc.   |  |
| 20 5 5 8  |                   |   |  | 176  |                       |                                      |   | ork Road,  | ·····                       |                           | yland 2°                       |  |  |
|   | 0                 | 23a. Part1. Enter the shock, or hear                                | he disease, or comp<br>rt failure. List only o | lications that caused<br>one dause on each lir | I the death. [<br>ne. | Oo not enter                         | the mode of                               | dying, such as cardia                            | c or respiratory            | arrest,                   |                                | Approximate<br>Interval Between<br>Onset and Death |  |
| Physician   |                   | Immediate Cause (   | (Final<br>n                                    | . Yneu   | mon                   | ia                                   |   |  |                             |                           |                                | Bays   |  |
| /Medical<br>Examiner  |                   | resulting in death)   |  | Due to (or as                                  | a consequen           | ce of):                              | Eai                                       | ( ve   |                             |                           |                                | Edavis   |  |
| ō.  | ē                 | Sequentially list cor<br>if any, leading to im<br>cause. Enter Unde | nditions,<br>nmediate                          | b. Que to (or as                               | a consequen           | ce of):                              | Jul                                       | iu C   |                             |                           |                                | Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan            |  |
| be executed<br>sician and<br>burial-transit   | Examin            | Cause (Disease or<br>that initiated events                          | injury   | · Caro   | liom                  | YOT                                  | THE                                       | 1  |                             |                           |                                | 10 years   |  |
| an an<br>rial-tr  |                   | resulting in death) L   |  | Due to (or as                                  | a consequen           | ce of):                              |   | )  |                             |                           |                                | )  |  |
| icate be<br>physici<br>s the bu   | Ical              |   | •  | d  |                       |                                      |   |  |                             |                           |                                |  |  |
| ing pl  | Med               | IF FEMALE:  |  |  |                       |                                      |   |  |                             |                           |                                |  |  |
| eath certific<br>attending pl   | lan/              | 23b. Was decedent<br>in the past 1,2                                | t pregnant                                     | 23c. If yes, outcome<br>1□Live birth           | 2 Fetal dea           | ath 3□E                              | ctopic pregr                              |  |                             |                           | 23d. Date of deli<br>Month     | very<br>Day Year                                   |  |
| that the de<br>ned by the a<br>detached f   | Physician/Medical | 1 ☐ Yes 2 ☐<br>9 ☐ Unknown  | No   | 4□Pregnant at<br>9□Unknown                     | time of deatr         | ) 5U(                                | Other (specif                             | у)   |                             |                           |                                |  |  |
| that t  |                   | Part II. Other signifi  | icant conditions co                            | entributing to death b                         | ut not resultin       | g in the und                         | erlying caus                              | e given in Part I.                               | 23e. Did                    | tobacco                   | use contribute to              | the cause of death?                                |  |
| 6 60  | ed by             | corona  | ry arte  | ery dist                                       | ease                  | ر                                    |   |  | 1 🗆                         | Yes                       | 2 □ No 3 □ Pr                  | obably 4 Unknown                                   |  |
| aw require<br>s been si   | Completed         | atrial  | fibr   | Matio  | n                     |                                      |   |  | 24a. Wa                     |                           | 24b. Were au                   | topsy findings available                           |  |
| The law<br>cate has l<br>page 2 s   | mo.               |   |  |  |                       |                                      |   |  |                             | opsy<br>formed?<br>2 12 N | death?                         | completion of cause of                             |  |
| ian:<br>rtifica<br>ctor, p  | Be C              | 25. Was case refer  |  |  |                       |                                      |   | 26. Place of De                                  |                             |                           |                                |  |  |
| nysic<br>nis ce<br>i dire   | 101               | examiner?   | No   | Hospital: Impatie                              | nt 2 ER               | Outpatient                           | 3□ DOA                                    | Other: 4 - Nursing I                             | Home 5 ☐ Res                | idence                    | 6 □Other (Spec                 | cify)  |  |
| To the Hospital or Attending Physician: The within 24 hours alter death.  To the Funeral Director: After this certificate completely filled in by the funeral director, pag   |                   | 27. Manner of Death<br>1 Delatural<br>2 Accident                    | h<br>5 Pending<br>investigation                | 28a. Date of Inju.<br>(Month, Da)              | ry Year) 28           | b. Time of<br>Injury                 | 28c.                                      | Injury at Work? 1 Yes 2 No                       | 28d. Describe               | how inj                   | ury occurred                   |  |  |
| or Atter<br>iter dea<br>irector<br>n by the   | Certification;    | 3 Suicide 4 Homicide  | 6 Could not be determined                      | 28e. Place of Inju-                            |                       | , farm, stree                        | t, factory, of                            | fice   | 28f. Location<br>City or To | (Street a                 | and Number or Ru<br>te)        | iral Route Number,                                 |  |
| urs al  |                   |   | <i></i>  |  |                       |                                      |   |  |                             |                           |                                |  |  |
| e Hosp<br>124 ho<br>e Fune<br>detely fi   | edical            | 29a. Certifier<br>(Check only<br>one)                               |  |  | examination           |                                      |   | he time, date and place<br>my opinion, death occ |                             |                           |                                |  |  |
| To th<br>Withir<br>To th  | M                 | 29b. Signature and  | title of certifier                             |  |                       |                                      | 29c. Li                                   | cense number                                     |                             | 29d. D                    | ate signed (Monti              | h, Day, Year)                                      |  |
| *******   |                   | M   | In AM  | mull   | MA                    |                                      | DO  | 066712   |                             | Febru                     | ary 13                         | 2003   |  |
| 0,4   |                   | 30. Name and addre  | ess of person who c                            | ompleted cause of d                            |                       |                                      |   |  |                             |                           | 14.5                           |  |  |
| - 01  |                   | MEUSSA<br>31. Date filed (Mont                                      | th. Day. Year)                                 |  | ar's Signature        |                                      | Jolfe S                                   | rveet B  | altimor                     | τ,                        | MD 21                          | 28+  |  |
| Sta<br>Registr  |                   | F   | FB 1 5 20                                      | 08   | a de                  | do                                   | A ST ST                                   |  |                             |                           |                                |  |  |
| MH 17 Rev 1/2   | 001               |   | LU LU LAN                                      | -  | 34                    | -                                    |   |  |                             |                           |                                |  |  |
|   |                   |   |  |  | 0                     | RIGINA                               | L   |  |                             |                           |                                |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien (1)

|             |   |                 | 1 - For<br>State<br>Registrar   |  |                                       | artment of li<br>rtificate of                           |                                    | Mental Hygier                            | lo.   |
|-------------|---|-----------------|---|--|---------------------------------------|---|------------------------------------|--|---|
|             | Physici   | an              | 1. Decedent's Name (First, Middle, La   | st)  |                                       |   |                                    |  | Day Year 1455 M   |
|             | /Medio  |                 | Esther G. Al.  4a. Facility Name (If not institution, giv   | e street and number)   |                                       | 4b. City, Town,   | or Location of Dea                 | the february                             | fc. County of Death   |
|             |   |                 | Johns Hopkins Bayvill   |  |                                       | Ba  | comere                             |  | Backemore   |
|             | Funeral<br>Director   |                 | 210-44-1094   | 6ex 2√XF 7. Age (  | In yrs. last birthday)<br>Yrs.        | If Under 1 Year<br>Months Days                          |                                    | . (Month, Day, Yea                       | 9. Birthplace (State or Foreign<br>Country) Maryland                        |
|             | yland   |                 | Usual Residence of Decedent  10a. State 10b. County   | 1  | 0c. City, Town or Lo                  | ocation   |                                    |  | 10d. Inside City Limits   |
|             | e Mari  | ctor            | Maryland None   |  | Baltimore                             | 9   |                                    |  | 1 X Yes 2 □ No  |
|             | 23a or 24   | Funeral Directo | 5055 Hopkins Bayview (  | Circle   |                                       | 10f. Zip Code   | 21224                              | 10g. (                                   | Ditizen of What Country? USA  |
| 5-0036      | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilw and Mental Hygiene. Department of Heatilw and Mental Hygiene. See I show more than 1 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Modical Exemities in ust be mullified at ODGe. | by              | 11. Marital Status  1 Never Married 2 Married   | 12. Was Decedent Even<br>Armed Forcas?<br>1 ☐ Yes <b>20</b> No<br>If Yes, Give<br>Year or Dates: |                                       | Was Decedent of<br>If Yes, specify Cub<br>1 ☐ Yes XX No | oan, Mexican, Pue                  | Specify Yes or No-<br>rto Rican, etc.)   | 14. Race - American Indian, Black, White, etc.  Specify: White              |
| 21215-0     | ithin 72 ho<br>ne.<br>nan "natur<br>Medical   | Completed       | 15. Decedent's E<br>(Specify only highest gra<br>Elementary/Secondary (0-12)                                | ducation<br>ade completed)<br>College (1-4or 5+)   | /ife.                                 | DO NOT use retire                                       | pation<br>during most of wo<br>ad) | orking 16b.                              | Kind of Business/Industry   |
| 2<br>2      | filed w<br>Hygier<br>ther th  | e Col           | 12<br>17. Father's Name (First, Middle, Last  | )  | Hc Hc                                 | memaker   | 18. Mother's Na                    | me (First, Middle, Maid                  | Own Home  |
| <u>lan</u>  | Ald be Alental rked o   | To Be           | William Croswell  |  |                                       |   |                                    | orsythe                                  |   |
| Maryland    | 12 should and hard hard hard hard hard hard hard har  |                 | 19a. Informant's Name/Relationship (  | •  |                                       |   |                                    |  | v or Town, State, Zip Code)   |
| آو<br>آ     | 1 and<br>Healti<br>tam 27   |                 | Charles H Abel 20a. Method of Disposition   | Son  | 20b. Place of Dispo                   | sition (Name of   |                                    | m, Maryland 2°                           | IU5/<br>Location - City or Town, State                                      |
| more,       | Pages<br>lent of<br>nt: If It   |                 | 20a. Method of Disposition  10 Burial 2 ☐ Cremation 3 ☐  14 ☐ Donation 5 ☐ Other (Specia                    |  | Cedar Hill                            | matory`or other pla<br>Cenetery                         | Feb 1                              | 5, 2008 Ba                               | ltimore, Maryland   |
| Balti       | permit. Departm Importa any inju  |                 | 2 Signature of Funeral de Lice  | in Kouar   | bis   22                              | 2. Name and Addr  | ess of Facility Mi<br>6500 York    | tchell-Wiedefe                           | eld Funeral Home Inc<br>re, Maryland 21212                                  |
|             | mH.   | 7               | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only                                 | plications that caused th<br>one cause on each line.   | e death. Do not ent                   | ter the mode of dy                                      | ing, such as cardia                | ac or respiratory arrest,                | Approximate<br>Interval Between   |
| E           | Medical   |                 | Immediate Cause (Final disease or condition resulting in death)   | a. Cerebra   |                                       | ular  | accid                              | ent                                      | Onset and Death   |
|             | Examiner  |                 |   | Due to (or as a d  | onsequence of):                       |   |                                    |  |   |
|             | P ==  | ner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as a c   | onsequence of):                       |   |                                    |  |   |
|             | icate be executed<br>physician and<br>s the burial-transit  | Examiner        | Cause (Disease or injury that initiated events resulting in death) Last                                     | cDue to (or as a c   | onsequence of):                       |   |                                    |  |   |
| 8760,       | e be e<br>/sician<br>e buria  | edical E        |   | d  | ,                                     |   |                                    |  |   |
| 99          |   |                 | IF FEMALE:  |  |                                       |   |                                    |  |   |
| O. Box      | The law requires that the death certific<br>its has been signed by the attending p<br>bage 2 should be detached for use as  | Physician/M     | 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 Mo 9 Unknown                                    | 23c. If yes, outcome of 1 Live birth 2 [ 4 Pregnant at time 9 Unknown                            | Fetal death 3                         | Ectopic pregnand Other (specify)                        | ey .                               |  | 23d. Date of delivery<br>Month Day Year                                     |
| т.<br>С     | res that t<br>igned by<br>be detac  | by Ph           | Part II. Other significant conditions   | ontributing to death but r   | not resulting in the u                | nderlying cause gi                                      | ven in Part I.                     | 23e. Did tobacc                          | use contribute to the cause of death?                                       |
| ords        | w require:<br>been sig<br>should b  |                 |   |  | · · · · · · · · · · · · · · · · · · · |   |                                    | 1 ☐ Yes                                  | 2 No 3 Probably 4 ∰Unknown  |
| Records,    | e law r<br>has be<br>je 2 sh  | Completed       |   |  |                                       |   |                                    | 24a. Was an autopsy                      | 24b. Were autopsy findings available prior to completion of cause of death? |
|             |   | e Col           | 25. Was case referred to medical  |  |                                       |   |                                    | performed                                |   |
| Vital       | ysicia<br>is certi<br>directo   | To Be           | examiner?  1 \( \sum \) Yes 2 \( \sum \) No   | Hospital:<br>1 ☐ Inpatient   | 2 ER/Outpatien                        | nt 3 DOA Ct   | her                                | hath (Check only one)  Home 5  Residence | 6 □Other (Specify)  |
| Division of | ding Ph<br>h.<br>After th<br>funeral  |                 | 27. Manner of Death 1 ☑Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Y   |                                       |   |                                    | 28d. Describe how in                     |   |
| Sio         | uttendi<br>death.<br>ctor: A<br>y the fu  | icatl           | 2 Accident investigatio   |  | At home form ste                      |   | Yes 2 No                           | 296 Location (Street                     | and Number or Divisi Bouts Number   |
| N<br>N      | or A  | Certification:  | 4 Homicide determined   | 28e. Place of Injury<br>building, etc. (   | - At nome, farm, str<br>Specify)      | eet, factory, office                                    |                                    | City or Town, Sta                        | and Number or Rural Route Number,<br>tte)                                   |
|             | To the Hospital within 24 hours a To the Funeral I completely filled  | Medical         |   |  | amination and/or in                   |   |                                    |  | (s) and manner as stated.<br>ind place, and due to the cause(s)             |
|             | To the within To the comple   | Me              | 29b. Signature and title of certifier   | 1  |                                       | 29c. Licen  | se number                          | 29d. I                                   | Date signed (Month, Day, Year)  |
| -           |   |                 | Stuse a. L.   | ardte mo   | )                                     | 039   | 763                                | Fu                                       | rusky 12 2008   |
| 0           | 7   |                 | 30. Name and address of person who  | completed cause of deal  | h (Item 23a) (Type,                   | Print)  | Co Bal                             | House M                                  | 1217266   |
|             | Sta   |                 | 31. Date filed (Month, Day, Year)   | 32. Registrar's  | Signature                             | ال  | C. C. LOVE                         | 11100 -                                  | ruary 12, 2008  |

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 07 Gloria Τ. Roone 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner reltimor Centrer Phare Kosedale Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months Min. 1 ☐ M 2 12 XF Hours 49 Director 213-72-6650 July 16,1958 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits ns 23a or 28a-f sh must be notified 1 ☐ Yes 2X No Director Middle River Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3814 Dunsmuir Road 21220 United States Apt. H Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Boone, Blond Baltimore, Maryland 21215-0036 1 Tyes 2 XNo Specify. þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Barmaid Tavern 9 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ann Buckingham Martin Lange 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3814 Dunsmuir Road Baltimore, MD 21220 Tracey Boone (Daughter) Apt. H it. Pages 1 an artment of Heals ortant: If item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State Hilltop Service Corp. 2/15/2008 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk ,Inc. 7922 Wise Ave. Dundalk. Maryland 2122 23a. and 1. Enter the disease, or commiscations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List any one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kespirator Failure Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner hronic. Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-transit sthma Due to (or as a consequence of) Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗆 🔭 s 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1□ Yes 2€ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has b 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≥ No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d, Describe how injury occurred

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: After

28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: Natural 5 Pending Injury 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and titl 29d. Date signed (Month. Dav. Year) D639 2/7/08

Sys

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 Frank mran 6 32. Registrar's Signature

31. Date filed (Month, Day, Year) EB 5

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Leonard Voil Buber, Sr. rebuary 2008 205 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN Square HospiTAL Center Rosedale Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1₩ M 2□F 213-26-7413 **Director** Nov. 27,1931 Maryland Usual Residence of Decedent death with the Maryland 10h. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1653 Poles Road 21221 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1¶Yes 2∏No IfYes, Give Year or Dates: Korea filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Be Completed by Specify: 3 ☐ Widowed 4 ☑ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and 2 should be filed we salth and Mental Hygier 27 is marked other the Business Owner Leonard's Seafood 10 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clithiro C. Buber Olive Murray 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Roxanna Kreiner (Daughter) 1649 Poles Road Essex, Maryland Injury or other permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c Location - City or Town, State 14 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation <sub>a</sub> 5 Dother (Specify) Bel Air Mem. Gdns. 2/15/2008 Bel Air, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
7922 Wise Ave. Dundalk, Maryland Inc. 21222 23a. Part1. Enter the rise and complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear rail e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician disease a. C. erebeovascular /Medical Due to (or as a consequence of). **Examiner** m etastatic maliquancy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsv performed Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 ☑ Natural 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0065094 MUM NOUYEN 641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NGUYEN 9000 FRANKLIN Square DRIVE md 21237 Baltimore DR BINH H 31. Date filed (Month, Day, Year) FEB 1 5 32 Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  | or State   | Maryland / Departme<br>Certifica  |                           |   | Mental Hy                            | giene<br>Reg. I                            | No. 20                                   | 108 01.37   |
|--|--|---|---------------------------|---|--------------------------------------|--|--|---|
| Physician/ 1. De<br>edical Examiner  | ecedent's Name (First, Middle,Last)  | Connie Ball   | erst                      | adt   |                                      | 2. Date of Death  Month Di February 10,    |  | 3. Time of Death<br>1115 hrs                                  |
| 4a. F  | Facility Name (if not institution, give stre<br>Bayview Hospital                               | et and number)  | 4t                        | City, Town, or Loc<br>Baltimore                             | cation of Death                      | ,,,  | 4c. County of Deat                       | h   |
| <b>Director</b> 2  | 6. Sex<br>213-68-9793  | 7. Age (In yrs. last birt)  | hday)<br>Yrs.             | If Under 1 Year Months Days                                 | If Under 24Hrs.<br>Hours Min.        | 8. Date of Birth (I                        | MM/DD/YYYY) 9. Bi<br>Forei<br>0,1956     |   |
| û 10a.   | al Residence of Decedent State 10b. County  ryland Balti                                       | 10c. City, Town   |                           |   |                                      |  |  | 10d. Inside City Limits  1 Yes 2 X No                         |
| the Maryland and a or 28a-f sh ilfred at once  | ryland Balti Street and Number 7609 North Point  |   | Edge                      | 10f. Zip Code   | 21219                                | "  | Citizen of What Co                       |   |
| sr death with to or items 23a must be not Funeral  | Never Married 2 X Married  | Was Decedent Ever in U.S. Armed Forces? Yes 2X No                                   | If Ye                     | Decedent of Hispa<br>s, specify Cuban, N                    | Mexican, Puerto                      |  | White, etc.                              | rican Indian, Black,  |
| 2 hours after "matural", "Examiner   Examiner   2   2   2   2   2   2   2   2   2  | . Decedent's Education (Specify only hi  | ates:<br>ghest grade completed) 16a.  | Decedent'                 | Yes 2 X No s<br>s Usual Occupation<br>st of working life. D | (Give kind of w                      |  | Specify: Wh                              |   |
| 21215-0036 uld be filed within 72 hour Mental Hygiene. marked other than "nature event, the Medical Exam  O Be Completed   | 10 Years Father's Name (First, Middle, Last)   |   | Man                       | ager 18   | Mother's Name                        | (First, Middle, Mai                        | Body Sho                                 | gp  |
| D 2121 Should be fi should be fi and Mental 1 To Be To Be  | Joseph Browne Informant's Name/Relationship (Type,   |   |                           |   | nd Number or R                       |  | er, City or Town, Sta                    | 1   |
| nore, ranges 1 and 1 to f Healt it. If item other transcript 1 X   | Mr. Leonard B. Bal Method of Disposition  X Burial 2 Cremation 3 F                             | 20b. Place of cremate cremater  | of Disposit<br>ory or oth | ion (Name of ceme   | tery,                                | Date 2                                     | Paw Paw                                  | or Town, State  |
|  | Signature of Funeral Service Leansee   | well!   | 22. Na<br>Du              | me and Address of<br>da-Ruck F                              | Facility<br>'uneral                  | Home of                                    | Dundalk,<br>arvland 2                    | Inc.<br>1222  |
| M-dical  |  | ons that caused the death. Do note.  Nertensive atherosto (or as a consequence of): | ot enter the              | e mode of dying, su   | ich as cardiac o                     | r respiratory arrest                       | s, shock, or heart                       | Approximate Interval<br>Between Onset and<br>Death            |
| Sequif an cause of the constant of the constan | juentially list conditions, hy, leading to immediate sees or injury that initiated conditions. | to (or as a consequence of):  |                           |   |                                      |  |  |   |
| be execu   | UNPENDED d.  | FNDED<br>#23a.PII.27.perME.   | 2877.                     | 3/3/08 TT   |                                      |  |  |   |
| tal Records, P.O. Box 68760, cim: The law requires that the death certificate be execut certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transport of the completed by Physician/Medical  | EMALE: Was decedent pregnant in the past 12 months?  Yes 2 No 9 Unknown                        | Live birth  Pregnant at time of death   | 2 Fet                     | er (Specify)  | Ectopic pregna                       | incy                                       | , 23d. Date of delive<br>Month           | Day Year  |
| ires that the de signed by the lbe detached for the detached for the by Phy  | t II. Other significant conditions cor<br>emphysema  | tributing to death but not resultin   | g in the u                | nderlying cause giv   | en in Part I.                        |  | 2 No 3 Pr                                | to the cause of death?  |
| Records,  The law require.  If cate has been sign, page 2 should be  |  |   |                           |   |                                      | 24a. Was an autopsy perform                | prior to death'                          | autopsy findings available ocompletion of cause of ? Yes 2 No |
| ing Physi<br>ing Physi<br>After this<br>uneral dir   | Manner of Death  |   | outpatient<br>Time of Ir  | 3 DOA O   | at Work?                             |  | esidence 6 Oth                           | ner:  |
| Division of To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After t completely filled in by the funeral ledical Certification: T  | A Natural 5 Pending Investigation Suicide 6 Could not be determined                            | 28e. Place of Injury - At home, f   | arm, stree                |   | s 2 No                               | 28f. Location (Str<br>or Town, Sta         |  | Rural Route Number, City                                      |
| To the Hospin within 24 hour rough et Funer completely fill (c) (c) (c) (d) (d) (d) (d) (d) (d) (d) (d) (d) (d   | Certifier 1 Certifying Physician:  | To the best of my knowledge, de the basis of examination and/or manner stated.      | ath occurr<br>investigati | ed at the time, date<br>on, in my opinion, o                | e and place, and<br>death occurred a | I due to the cause<br>at the time, date ar | (s) and manner as sind place, and due to | ated.<br>the cause(s)   |
| 296.   | Signature and title of certifier  Mune bears   | e (0, m)  |                           | 29c. License<br>O.C.M                                       |                                      |  | 29d. Date signed (A                      |   |
| 0 1  |  | tant Medical Examiner   | 111 P                     | enn Street, Ba  | Itimore, MD                          | 21201                                      |  |   |
| State <sup>31. t</sup><br>Registrar  | Date filed (Month, Day, Year)  | 32. Registrar's Signature   | Ano                       | AL.   |                                      | ·  |  |   |

DHMH 17 KeV 1/200Т ОСМЕ 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Date of Birth (Month, Day, Year) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Months 240-34-924 1 □ M 2 💢 Hours Days Director Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f showevent, the Medical Examiner must be notified at 1 ☐ (es 2 ☐ No Director MD timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code E. Northern 15/4 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify. þ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life\_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Dusewi Fe  $Ome \leq$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1CO 105 mma Hararove 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number bity or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any Injury or other trainonce. Annie Bullock 2407 E. Worthern aughter Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) disense MONAN **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached for 1 ☐ Yes 2 ☐ No 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MJnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform certificate Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2**51.**No Other: 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) 1 🗌 Yes P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physicial 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a, Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)

2 9 200 29b. Signature

State Registrar 31. Date filed (Month, Day, Year)

2008

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. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month OPAL GRAY BIRKMIRE 22:10 FEBRUARY 13, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BET. HARFORD If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours Min 1 □ M 25 F 215-28-4145 76 July 5, 1931 Maryland Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2102 Mark Street 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 ₩idowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Budget Analyst U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Daylor Smith Mary Virginia Weaver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Charlotte D. Smith / Sister</u> 1406 B Joppa Forest Drive, Joppa, MD 21085
e of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Grdn 2-18-08 4 ☐ Donation / 5 ☐ Other (Specify) Bel Air, Maryland 21. Signature Funery Service Inc. 22. Name and Address of Facility
McComas Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Immediate Cause (Final) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Line, Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at i Mental Hygiene. permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trauonce. Physician /Medical Examiner sician and bunal-transit Physician: The law requires that the death certificate be executed signed by the attending physician be detached for use as the buria Birkmire, Ooal Gray M9003 Division of Vital Records/P.O. Box 687 within 24 hours a

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

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Completed

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**Funeral** 

Director

Certification: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of ce 29c. License number D0059855 | February 14, 2008 where MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m. D. 500 Upper Chesapeake Dr. Bel Air, mp 21014 CYINA 31. Date filed Month, Day, Year) State Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® For State Registrar Amend #1,perMD,g877 3/10/08 TT Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year Month 22PM **Physician** 3008 /Medical 4c. County of Deat acility Name (If not institution, give street and number) Town, or Location of Death Examiner Birthplace (State or Foreign If Under 24 Hrs. If Under 1 Year **Funeral** Days 1₫M 2□F Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. Count 10c. City) Town of Location , or itams 23a or 28a-f show other traumatic event, the Medical Examiner must be notified a 1 Yes 2 No by Funeral Director 10g. Citizen of What Country? 10f. Zin Code filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced "natural". Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working

Wife DONOT use retired) 15. Decedent's Education (Specify only highest grade completed) il Hygiene. Elementary/Secondary (0-12) Pages 1 and 2 should be f nent of Health and Mental I int: If Item 27 Is marked of 9b. Mailing Address Place of Disposition (Name of Method of Disposition Department of H
Important: If Ite
any injury or of
once. 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, as the IF FEMALE: use If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year detached for in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Probably 2 🗆 No 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No filled in by the funeral director, page 2 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one 20 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 1 Tes 1 Inpatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and Hit Miladelma Re Sute 108 Bellmon My 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 📗 🗸 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Bobbitt Anne Mary 13. February 2008 8:20AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Golden Living Center Westminster Carroll 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Aug. 7,1920 Birthplace (State or Foreign Country) Days 1 □ M 2 🛛 F Months Hours Director 213-18-3515 87 MD Usual Residence of Decedent death with the Maryland 10b. County item 27 is marked other then "naturel", or items 23e or 28e-f show other treumstic event, the Medical Examinating matter all 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2√ No MD Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Timber Ridge Drive 21157 by Funeral USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then \*nt any injury or other treumatic event. The Medis 900cs. Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Theodore Zachidny Tekla Zacharkiw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl A. Bobbitt 201 Cork Lane, Reisterstown, MD Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial 2/15/08 Finksburg, MD 21. Signature of Furleyal Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or a Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Box 68760. physician cal the Physician/Med ası IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Month Day 4☐Pregnant at time of death 5 Other (specify) PO the 9□ Unknown 9 ☐ Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? þ pe Completed 1 Yes 2 No 3 Probably 4 Unknown Deen 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has page certificate t Division of Vital 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending After 1 Natural 2 Accident (Month, Day Year) 5 Pending after death.

Director: Af
d in by the fur investigation 1 TYes 3 🔲 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signa e and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eg

State Registrar olm

31. Date filed (Month, Day, Year)

. Registrar's Signature

address of person who completed cause of death (Item 23s)

2008

|   |   |                  | 1-State<br>Registrar Amend 20b, perFHC876, 2/15/0  | 8 TT Ce             | rtificate of  | Death  | Reg                                       | g. No. 2008                   | 3 04375  |
|---|---|------------------|--|---------------------|---|--|---|-------------------------------|--|
| 175   | Physici   | an               | Decedent's Name (First, Middle, Last)  |                     |   |  | 2. Date of Death                          | Day Year                      | 3. Time of Death                                 |
|   | /Medic  |                  | LEONARD  |                     | # 07 T  | BROWN  | FEBRUARY                                  |                               |  |
|   | Examin  | ier              | 4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER   |                     | RANDALLS  | r Location of Death                          |   | 4c. County of Dea             |  |
| F   | uneral  | 300              | 5. Social Security Number 6. Sex 7. Age (In y  | rs. last birthday)  | If Under 1 Year                                       | If Under 24 Hrs.                             | 8. Date of Birth                          |                               | thplace (State or Foreign                        |
|   | irector   |                  | 220-07-8276 1 <sup>1</sup> X <sup>™ 2□ F</sup> 88  | Yrs.                | Months Days   | Hours Min.                                   | 8. Date of Birth<br>Month, Day<br>05/21/1 | [919]                         | MD MD  |
| and   | M. J.   |                  | Usual Residence of Decedent  10a. State 10b. County 10c.   | City, Town or Lo    | ocation   |  |   |                               | 10d. Inside City Limits                          |
| Maryli  | f sho   | ro               |  | BALTIMOR            | F   |  |   |                               | 1 □Yes 2 No                                      |
| h the   | r 28a   | Funeral Director | 10e. Street and Number   | , LI IIION          | 10f. Zip Code   |  | 10  | g. Citizen of What C          | ountry?  |
| ith wit   | 23a o<br>ust be   | al D             | 1500 BEDFORD AVENUE, APT. 10   | 6                   |   | 21208  |   | US                            | SA   |
| er dea  | tems<br>ler m   | nuel             | 11. Marital Status 12. Was Decedent Ever in Armed Forces?  | U.S. 13.            | Was Decedent of H<br>If Yes, specify Cub              | lispanic Origin? (Spe<br>an, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)          | 14. Race - Am<br>Black, Whi   |  |
| Ital yiallo Z IZ IS-10000 2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene. | Il", or<br>xamir  | by F             | 1 □ Never Married 2 □ Married 1 □ X es 2 □ No If Yes, Give 3 X Widowed 4 □ Divorced Year or Dates:   |                     | 1 □ Yes 2 □ <b>X</b> No                               | Specify:                                     |   | Specify:                      | WHITE  |
| 2 pg  | atura<br>ical E   | ted              | 15. Decedent's Education<br>(Specify only highest grade completed)   | 16a. Dece           | dent's Usual Occup                                    | pation                                       | 11  | 6b. Kind of Business          | /Industry  |
| ithin 7   | Med "r  | Completed        | Elementary/Secondary (0-12) College (1-4or 5+)   | - life.             |   | during most of worki<br>d)                   | ng  | CHOE                          |  |
| iled w  | nt, the   |                  | 17. Father's Name ( <i>First, Middle, Last</i> )   |                     | OWNER   | 18. Mother's Name                            | (First Middle M                           | SHOES                         | )  |
| d be fental l   | c eve   | To Be            | LOUIS  | BR                  | OWN   | LENA   | (7 mai, madro, m                          | GOLDBER                       | RG   |
| shoul   | s marl<br>umati   | F                | 19a. Informant's Name/Relationship (Type. Print)   |                     |   |  | l Route Number,                           | City or Town, State,          |  |
| and 2   | n 27 is<br>er tra   |                  | LINDA CHANDLER / DAUGHTER  |                     |   | IL WAY, PO                                   | TOMAC, N                                  | MD 20854                      |  |
| permit. Pages 1 and 3 Department of Health  | Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, <u>the Medical Examiner must be notified at once.</u> |                  | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State   | Place of Dispo      | osition (Name of<br>matery or other place<br>AIM CONG | ce) 2/14/2                                   | 2008                                      | 0c. Location - City or        | Town, State                                      |
| t. Pa   | rtant:<br>njury   |                  | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee  |                     | AIM CONG  |  |   | BALTIMORE,                    |  |
| Depa  | Impo<br>any ir<br>once.   |                  | 21. Signature of Purieral Service Licensee   |                     |   | . 20   |   | SON & BROS<br>PIKESVILLE      |  |
|   | 139   |                  | 23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.   |                     |   |  |   |                               | Approximate Interval Between                     |
| Phy   | sician  |                  | Immediate Cause (Final disease or condition  | leratic             | Cardian   | ascular l                                    | ) isaces                                  | 2                             | Onset and Death                                  |
|   | edical<br>miner   |                  | resulting in death)  Due to (or as a cons  |                     |   |  |   |                               |  |
|   |   | e                | Sequentially list conditions, if any, leading to immediate Due to (or as a cons  | equence of):        |   |  |   |                               |  |
| pent /  | ansit   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  |                     |   |  |   |                               |  |
| e exec  | ian an<br>ırial-tr  |                  | resulting in death) Last   | equence of):        |   |  |   |                               |  |
| The law requires that the death certificate be executed   | ding physician and se as the burial-transit   | Medical          | d  | <i>*</i>            |   | -  |   |                               |  |
| certifi   | iding p   |                  | IF FEMALE: 23c. If yes, outcome pf pre-  | gnancy              |   |  |   | 23d. Date of de               | Nivon  |
| death   | atter<br>d for u  | hysician/        | in the past 12 months?  1  | etal death 3        | ∃Ectopic pregnancy<br>∃Other (s <i>pecify</i> ) _     | у  |   | Month                         | Day Year   |
| at the  | been signed by the attendir<br>should be detached for use   | hys              | 9 ☐ Unknown  |                     |   |  |   |                               |  |
| res tha   | igned<br>be de  | by P             | Part II. Other significant conditions contributing to death but not  | esulting in the u   | nderlying cause giv                                   | en in Part I.                                |   |                               | o the cause of death?                            |
| requi   | hould   | eted             |  |                     |   |  | 1 ☐ Yes                                   |                               | robably 4 Unknown                                |
| he law  | ge 2 s  | Completed        |  |                     |   |  | 24a. Was an<br>autopsy<br>perform         | prior to                      | utopsy findings available completion of cause of |
| iii iii   | or, pa  |                  | 25. Was case referred to medical   |                     |   | 26. Place of Death                           | 1□ Yes 2                                  | No 1 □Ye                      | s 2NNo   |
| ysicia  | direct  | To Be            | examiner?  | ER/Outpatier        | nt 3□ DOA Oth   | or:  |   | nce 6 Other (Spe              | ecify)   |
| . g.  | offer the   |                  | 27. Manner of Death 28a. Date of Injury  Natural 5 □ Pending (Month, Day Year,   | 28b. Time of Injury | f 28c. Injui<br>Wor                                   | ry at // /                                   | 28d. Describe how                         | v injury occurred             |  |
| ttend<br>death.   | the fr  | cati             | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be  | home farm et        |   | Yes 2 □ No                                   | 29f Logation /Ctm                         | and Alumbar or F              | lural Pauta Akumbar                              |
| alorA   | d in by   | Certification:   | 4 Homicide determined building, etc. (Spe  | cify)               | eer, ractory, office                                  | 1  | City or Town,                             | eet and Number or F<br>State) | urai noute Nurriber,                             |
| To the Hospital or Attending Physician: within 24 hours after death.  | To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2  |                  | 29a. Certifier (Check only (Ch | nowledge, deat      | h occurred at the ti                                  | me, date and place,                          | and due to the car                        | use(s) and manner a           | s stated.  |
| thin 24   | the F   | Medical          | one) and manner stated.  29b. Signature and title of contifier.  |                     | 29c. Licens   |  |   |                               |  |
| To Vilv   | <b>₽</b> 8  |                  | This hand the Man II.  | 1.                  | ) I C   |  |   | d. Date signed (Mon           |  |
| 3   | et  |                  | 30 Name and address of person who completed cause of death (I  | tem 28a) (Type,     | Print)  | oeg/   | \ \r <del>(</del>                         | 2014an                        | 12,000   |
| 1   | 1   |                  | Philip Militelle MD 67   | irlabl              | 111/10  | T Luthe                                      | wille 1                                   | ebruaze<br>Ud zio             | 13   |
|   | Sta<br>Registr  |                  | 31. Date filed (Month, Day, Year) 462. Registrar's Sign FEB 1 5 2008   | mature              | NE)   |  | •   |                               |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 3:53 allace DRUARY 07 2008 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Medical Rayrica Hopkins Baltimore Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Min 1**X**M 2□ F 212-40-2518 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ in any inury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced as 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/ dc/ndary (0-12) College (1-4or 5+) Morgan State Univ. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Paral Route Number, City or Town, State, Zip Code) 294151 in Chester 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee W013P 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STROKE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1旦Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) is certificate has been signed by the director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed a No 2 ☐ No 1 Ves Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation Injury 1 Yes 2 No after death Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 15 FEB

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Mary Chumley 9:05M February 13, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hart Heritage Forest Hill Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1□M 2√F 220-20-2356 79 Yrs. Director 12/16/1928 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notified at MD. Harford 1 ☐ Yes 2 XNo Forest Hill Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ed other than "natural", or Items 23a or event, the Medical Examiner must be a 1910 Jean Court 21050 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Item 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Be Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosaria Maggio Joseph Carpintieri 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1910 Jean Court Forest Hill, MD. 21050 Julia A. Smith/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 02/19/08 any injury or Parkville, MD. Parkwood Cemetery 22. Name and Address of Facility 8800 Harford Rd. Parkville, Md. Evans Funeral Chapel & Cremation Services 21. Signature of Funeral Service Licensee v1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heat frillure. List only one cause on each line. VMCUIN Accorded ereBish Immediate Cause (Final ~ 6wER145 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burla Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4 □ Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ASSIS Lead Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA care Other: 4 Nursing Home 5 Residence 6 Sther (Specify) 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 739885 - MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. MACABAIL BELAIN MA 21014 SPAMUS 625 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician 2032 PM 70 Februar OF 20091 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. ial Security Number 6. Sex 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Yrs. 219-16-3287 97 29, 1910 Virginia Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐Yes 2 No Director Maryland Harford Edgewood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2204 Snow Road 21040 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: ģ White 3 Widowed 4 ☐ Divorced er than "natura", the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hyglen. Important: if item 27 is marked other that any Injury or other traumatic event, the I once. Owner/Operator Grocer Store 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Marchel Reed Anne Cora Nichols ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3140 Abingdon Road, Abingdon, Maryland 21009
Disposition (Name of Date 20c. Location - City or Town, State Ralph W. Roberson III / Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial ≥ 2 Cremation 3 □Removal from State Bel Air Memorial Grdn 2-15-08 Bel Air, Maryland 4 ☐ Donation 5 ☐ Offigr (Specify) 21. Signa e of Funeral McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. art1. Enter the sease, or mplications to the used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 15 minuk /Medical Due to (or as a consequence of): Examiner archoin UC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical Box ( IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy Month 5 Other (specify) 9□Unknown o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?/ Yes 2 No 2 No 1□ Yes 1 ☐ Yes Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Inpatient 2 ▼ER/Outpatient 3 DOA 1 Tes Certification: To o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide i 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertified 09 2000 who completed cause of death (Item 23a) (Type, Print) 30, Name and address of person 500 21014 Komi 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician February 4 2000 TYRONE CHAMPION 4 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Doctor's Hospital Prince Georges Lanham-seabrook If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 € M 2 □ F 45 28,1962 Wash., Director 579-92-4976 Apr. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ortant; If Item 27 Is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Mitchelville MD Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10616 Vista Grande Dr. 20721 USA Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 3altimore/Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Loan Officer Private permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important: If Item 27 Is marked other I any injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( 2 John Champion Alice Veney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20721 19a. Informant's Name/Relationship (Type. Print) Lisa Champion/wife 10616 Vista Grande Dr./Mitchelville, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □Cremation 3 □Removal from State 4 ☐Donation 5 ☐ Other (Specify) 02/13/08 | Suitland, MD Lincoln Memorial 21. Signature of Fundament 22. Name and Address of Facility Reese Professional Funeral Service Licensee Service, 3605 14th St. NW, Wash., DC20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Infarction ocardia **Physician** /Medical Due to ( as a consequence of): Examiner a betes UNKHOWN Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 4 Examine Hypertension ig physician and as the burial-transit death certificate be execut Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Unlenowa ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ☐ ER/Outpatient 3 ☑ DOA 1 ☐ Yes 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of e Hospital or Attending Po 24 hours after death. e Funeral Director: After the letely filled in by the funera Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 8118Good L ucickd., Lanham, Zwally

State Registrar 31. Date filed (Month, Day, Year)

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**Physician** /Medical **Examiner** attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Directo

Funeral

þ

Completed

Be

၉

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

|   | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only            | plications that caused the deal  | h. Do not enter the                           | mode of dying, such as cardia  | c or respiratory arrest,                             |                          | Approximate<br>Interval Between                  |
|---|---|--|---|--|--|--------------------------|--|
|   | Immediate Cause (Final disease or condition   | a. Alzh  | eime  | _  |  |                          | Onset and Death                                  |
|   | resulting in death)   | Due to (or as a conseq   | uence of):                                    |  |  |                          |  |
| iner                                    | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying      | b. Due to (or as a conseq  | uence of):                                    |  | -2.  |                          |  |
| Exam                                    | Cause (Disease or injury that initiated events resulting in death) Last                 | c<br>Due to (or as a conseq  | uence of):                                    |  |  |                          |  |
| dical                                   | •   | d  |   |  |  |                          |  |
| Completed by Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ 10 9 □ Unknown | 23c. If yes, outcome pf pregnative birth 2 ☐ Feta<br>4☐ Pregnant at time of of<br>9☐ Unknown | al death 3 Ectop                              | ic pregnancy<br>r (specify)  |  | 23d. Date of de<br>Month | livery<br>Day Year                               |
| d by Pr                                 | Part II. Other significant conditions of  | Ulcera   |   | ng cause given in Part I.  |  |                          | o the cause of death?                            |
| Complete                                | Nothe trans   | Iceration les  | rcien   | > _  | 24a. Was an autopsy performed?                       | death?                   | utopsy findings available completion of cause of |
| Be (                                    | 25. Was case referred to medical examiner?  |  |   | 26. Place of Dea   | ath (Check only one)                                 |                          |  |
|   | 1  Yes 2 No   | Hospital: 1 ☐ Inpatient 2 ☐  | ER/Outpatient 3                               | DOA Other: 4 Nursing H   | lome 5 nesidence                                     | 6 □Other (Spe            | cify)  |
| ation:                                  | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation                       | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of<br>Injury<br>M                   | 28c. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No                            | 28d. Describe how in                                 | ury occurred             |  |
| Sertifica                               | 3 Suicide 6 Could not be determined   | 28e. Place of injury - At he building, etc. (Special   | ome, farm, street, fa                         | ctory, office  | 28f. Location (Street<br>City or Town, Sta           | and Number or Rite)      | ural Route Number,                               |
| Medical Certification: To               | 29a. Certifier (Check only one) 1 ☐ Certifying Phyone 2 ☐ Medical Exam                  | ysician: To the best of my kno<br>liner: On the basis of examina<br>and manner stated.       | owledge, death occu<br>ation and/or investiga | rred at the time, date and place<br>ation, in my opinion, death occi | e, and due to the cause<br>urred at the time, date a | (s) and manner as        | s stated.<br>e to the cause(s)                   |
| ž                                       | 29b. Signature and title of certifier   | eu   |   | 29c. License number 0053 2   | 29d. E   | ate signed (Mona         | th, Day, Year)                                   |
| Ì                                       | 30. Name and address of person who  | completed cause of death (Iten   | n 23a) (Type, Print)                          |  |  |                          |  |

State Registrar Darryl A. Hill, MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

13635 Baltimore Avenue Laurel, Maryland

| For                | State of Maryland / Department | of Health |
|--------------------|--------------------------------|-----------|
| State<br>Registrar | Certificate                    | of Death  |

|                            |   |                | 1 - State<br>Registrar   | (   | Certificate of Death  |                                     | Reg. No.                           |  |
|----------------------------|---|----------------|--|---|---|-------------------------------------|------------------------------------|--|
|                            |   |                | Decedent's Name (First, Middle, La.                                    | st)   |   | 2. Date of D                        | eath                               | 3. Time of Death                       |
|                            | Physici   |                | CALVIN   |   | MHIM  | Fe bry                              | Day Year                           | - 1 2 M                                |
|                            | /Medic<br>Examir  |                | 4a. Facility Name (If not institution, give                            | e street and number)  | 4b. City, Town, or Location of Dea  |                                     | 4c. County of De                   |  |
|                            |   |                | The Johns Hos  | okins Hospital  | balti moi   | re Citu                             | ,                                  | N/A                                    |
|                            | Funeral   |                | 5. Social Security Number 6.   | Sex 7. Age (In yrs. last birtho   | day) If Under 1 Year If Under 24 Hrs  | 8. Date of B                        |                                    | rthplace (State or Foreign             |
| П                          | Director  |                | 216-32-7936  | M 2□F 83 Yr   | s. Months Days Hours Min  | Aug. 1                              | 16, 1924 Mai                       | cyland                                 |
|                            | p ,   |                | Usual Residence of Decedent  10a. State 10b. County                    | 100 City T  |   |                                     |                                    |  |
|                            | anyla   | -              |  | 10c. City, Town o   |   |                                     |                                    | 10d. Inside City Limits 1 □XYes 2 □ No |
|                            | 98a-f   | Director       | Md. N/A  |   |   | ore City                            |                                    | 101                                    |
|                            | with the  | Dire           | 10e. Street and Number   | C1  | 10f. Zip Code   |                                     | 10g. Citizen of What C             | ountry?                                |
|                            | ath v   | rai            | 4100 N. Charles  |   | 21218   |                                     | USA                                |  |
|                            | er de<br>Items  | Funerai        | 11. Marital Status   | Armed Forces?   | <ol> <li>Was Decedent of Hispanic Origin? (<br/>If Yes, specify Cuban, Mexican, Puer</li> </ol> | Specify Yes or N<br>to Rican, etc.) | 14. Race - Am<br>Black, Wh         |  |
| 36                         | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or Items 23s or 28s-f show<br>the Medical Examinat man by position at  | by F           | 1 ☐ Never Married  | 1X∑Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates: WWII                                | 1 ☐ Yes 2 No Specify:   |                                     | Specify:                           | Asian                                  |
| 21215-0036                 | hou   | ed             | 15. Decedent's Ed  |   | ecedent's Usual Occupation  |                                     | 16b. Kind of Busines               |  |
| 15                         | n ne  | Completed      | (Specify only highest gra  | ade completed) ((   | Give kind of work done during most of wo<br>fe. DO NOT use retired)                             | orking                              | Baltimore                          | ,                                      |
| 72                         | with<br>iene.   | E O            | Elementary/Secondary (0-12)  | College (1-4or 5+)<br>5+  | Chairman  |                                     | Appeals Bo                         |  |
|                            | Hyg<br>other  | BeC            | 17. Father's Name (First, Middle, Last)                                | 1   | 18. Mother's Na   | me (First, Middle                   | e, Maiden Sumame)                  | <u>/u _u</u>                           |
| lan                        | ld be<br>lenta<br>ked<br>ked  | To B           | Chin   | Quon  |   | Lee Fun                             | ng Ho                              |  |
| Maryland                   | shou<br>nd M<br>mar   | _              | 19a. Informant's Name/Relationship (                                   | Type, Print) 19b. N   | failing Address (Street and Number or R   |                                     |                                    | Zip Code)                              |
|                            | permil. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, it a Medical Examination in all by Inditional anges. |                | Mrs. Katherine M.  | Chin/Wife 410   | O N. Charles St. U  | nit 208                             | Baltimore.                         | Md. 21218                              |
| Baltimore,                 | s 1 a<br>if Hei<br>item<br>othe   | 1              | 20a. Method of Disposition   | 20b. Place of D   | isposition (Name of crematory or other place)   | Date                                | 20c. Location - City o             |  |
| Ë                          | Page<br>ent c<br>nt: If<br>ry or  |                | 1 ☑ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specific        | Themoval from State   | Valley Mem. Grd. 2  | 2/16/00                             | Timonium 1                         | lanuland                               |
| äĦ                         | mil.  |                | 21. Signature of Funeral Service Lices                                 |   | 22. Name and Address of Facility RI   | ick Towe                            | on Funeral                         | Home Inc                               |
| ä                          | Deparimonal Importance  |                | myhael   | 1 Rush  | 1050 York Road To   | owson. M                            | laryland 212                       | 7011e, 111c.                           |
|                            |   |                | 23a. Part1. Enter the disease, or con-                                 | plications that caused the death. Do not one cause on each line.                    |   |                                     |                                    | Approximate                            |
|                            | Physician   |                | Immediate Cause (Final   | V 14  |   |                                     |                                    | Interval Between<br>Onset and Death    |
|                            | /Medical  |                | disease or condition resulting in death)                               | a. Lach'z ac  Due to (or as a consequence of)                                       |   |                                     |                                    | 2arys                                  |
| В                          | Examiner  |                |  | h Hugotense To  |   |                                     |                                    | 2 days                                 |
|                            |   | e              | Sequentially list conditions, if any, leading to immediate             | b. Due to (or s a consequence of)   | 1   |                                     |                                    |  |
|                            | uted  | Examin         | cause. Enter Underlying Cause (Disease or injury that initiated events |   |   |                                     |                                    | 1                                      |
| Ć,                         | exec<br>n an  | Exa            | resulting in death) Last   | Due to (or as a consequence of)   |   |                                     |                                    |  |
| 68760,                     | le be<br>/sicia<br>e bur  |                |  | d   |   |                                     |                                    |  |
| 68                         | eath certificate be executed<br>attending physician and<br>for use as the burial-transit  | Medical        |  |   |   |                                     |                                    |  |
| ŏ                          | h cer<br>endin<br>use   |                | IF FEMALE:<br>23b. Was decedent pregnant                               | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death                    | 2 C Catania   |                                     | 23d. Date of de                    | alivery                                |
| .O. Bo                     | The law requires that the death ate has been signed by the atter page 2 should be detached for u  | Physician      | in the past 12 months? 1 Yes 2 No                                      | 4 Pregnant at time of death   | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)   |                                     | Month                              | Day Year                               |
| <u>Ф</u>                   | tt Ihe<br>by th<br>tache  | hys            | 9 🗆 Unknown  | 9☐ Unknown  |   |                                     |                                    |  |
|                            | s tha   | by P           | Part II. Other significant conditions o                                | ontributing to death but not resulting in th  | ne underlying cause given in Part I.  | 23e. Did                            | tobacco use contribute             | to the cause of death?                 |
| ğ                          | w require<br>been sign<br>should b  | ed             | Coverany arte  | my direase  |   | 1 🗆                                 | Yes 2 tho 3□F                      | Probably 4 Unknown                     |
| S                          | awre<br>is be   | plet           | ′  | ,   |   | 24a. Was                            | s an 24b. Were a                   | utopsy findings available              |
| m                          | The I   | Completed      |  |   |   |                                     | ormed? death?                      |  |
| <u>ta</u>                  |   | Bec            | 25. Was case referred to medical                                       |   | 26. Place of De   | 1 ☐ Yes<br>ath (Check only          |                                    | 3 22/10                                |
| >                          | Attending Physician: r death. ector: After this certific by the funeral director.   | 0              | examiner?  | Hospital: 1 Impatient 2 ☐ ER/Outpa  | Other   |                                     | idence 6 Other (Spe                | ecify)                                 |
| Division of Vital Records, | ig Ph<br>ter th   | T:U            | 27. Manner of Death  | 28a. Date of Injury<br>(Month, Day Year) 28b. Tim                                   | e of 28c. Injury at   | 7                                   | how injury occurred                |  |
| 0                          | ath.<br>r: After<br>ne funer  | atic           | 1 Accident 5 Pending investigation                                     |   | M 1 Yes 2 No  |                                     |                                    |  |
| <u> </u>                   | l or Attendated after death Director:   | E E            | 3 ☐ Suicide 6 ☐ Could not be determined                                | 28e. Place of Injury - At home, farm building, etc. (Specify)                       | , street, factory, office   |                                     | (Street and Number or Fown, State) | Rural Route Number,                    |
|                            | tal or A  | Certification: |  | ,   |   | 1                                   | , 0.2.0,                           |  |
|                            | hour<br>uner<br>uner  |                | 29a. Certifier 1 Certifying Ph   | ysicien: To the best of my knowledge, oniner: On the basis of examination and/o     | leath occurred at the time, date and place  | e, and due to the                   | cause(s) and manner a              | s stated.                              |
|                            | the H<br>in 24<br>in 24<br>ine F  | edical         | one)   | and manner stated.  |   |                                     |                                    | e to the cause(s)                      |
|                            | To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by  | Σ              | 29b. Signature and title of certifier                                  |   | 29c. License number   |                                     | 29d. Date signed (Mon              | th, Day, Year)                         |
| į                          |   |                | 1 Delalot  | ~ MEDICAL DUCTE   | R RESTOU  |                                     | 2/13/08                            |  |
| 26                         | 1   |                | 30. Name and address of person who                                     | completed cause of death (item 23a) (Ty   | pe, Print)  |                                     |                                    |  |
| 11.                        | 111   |                | BRUCE SABATH   | 600 NOFTH WOLFE.  | ST BALTIMORE, MA  | 24610                               | D 21287                            |  |
|                            | Sta   |                | 31. Date filed (Month, Day, Year)                                      | completed cause of death (Item 23a) (Ty  600 Naffth WOLFE  32 Registrar's Signature | 1938  |                                     |                                    |  |
| La                         | Registr   | alf            | LEDIDE   | and the same of   | 9   |                                     |                                    |  |

FEB 1 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 322 M SEBASTIAN JOSEPH CORRAL, JR. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A GOOD SAMARITAN HOSPITAL Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Months 1 X M 2 ☐ F Director 213-34-6050 Jul 19, 1930 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No ral", or items 23a or 28a-f sl Examiner must be notified Directo Baltimore Maryland Baltimore County 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21234 1900 Glen Keith Boulevard by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ¥ Yes 2 □ No Specify: Spainish Specify. 3 Widowed 4 Divorced White natural" Completed Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Defense Contractors Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sierra Sebastian Joseph Corral, Sr. Maria 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1900 Glen Keith Boulevard, Baltimore, Maryland21234 Mrs. Alice T. Corral 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/15/2008 Baltimore, Maryland 4 Donation 5 Other (Specify) Parkwood Cemetery 21. Signature of Juneral Service (censee

Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit isease Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4⊡Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 ☐Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician; rector. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ►R/Outpatient 1 Inpatient 3□ DOA Certification: To 27. Manuer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier within 24 ho To the Fune completely f and manner stated 29b. Signature 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Wheeler

2008

34110

31. Date filed (Month, Day, Year)

32. Registrar's Signature

| 116. S     | , |
|------------|---|
| Box 68760, |   |
| P.O.       |   |
| Records,   |   |
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|  |                     |   | Please                               | e Type or Pri  |              |   |   |   | -                                |                          | -                                       |  |
|--|---------------------|---|--------------------------------------|--|--------------|---|---|---|----------------------------------|--------------------------|---|--|
|  |                     | for State Registrar   |                                      | State of M   | arylan       |   | artment of H<br>rtificate of I  |   | Mental Hy                        | giene<br>Reg. No.        | 2008                                    | 04389  |
| Physici<br>/Medic  |                     | 1. Decedent's Nam   | E. Cart                              | hens   |              |   |   |   | 2. Date of De Month 2 – 0 6 – 2  | Day                      | Year                                    | 3. Time of Death 22:50 M                         |
| Examir<br>Funeral<br>Director  | ner                 |   | George George 6.                     | 1DXM 2DF   | al           | la <i>st birthd</i> ay)<br>Yrs.         | Chever  If Under 1 Year  Months Days  | Location of Death  V If Under 24 Hrs. Hours Min.                  | 8. Date of Bil                   | rth<br>ay, Year)         | C                                       | thplace (State or Foreign ountry)                |
| 0  |                     | Usual Residence of  | f Decedent                           |  |              |   |   | <u></u>   | 06-14-                           | -193                     |   | N.C.   |
| farylar<br>show  | or                  | 10a. State  | 10b. County                          |  |              | , Town or Lo                            | cation  |   |                                  |                          |   | 10d. Inside City Limits 11€ Yes 2 No             |
| r 28a-   | irect               | MD<br>10e. Street and Nu  | P.G.                                 |  | ьапс         | dover                                   | 10f. Zip Code   |   |                                  | 10g. Citiz               | zen of What C                           | ountry?  |
| tth with use 23a oust be   | ralD                | 6708 W.   | Forest                               | Rd.  |              |   | 20785   |   |                                  | U.                       | S.A.                                    |  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral Director | 11. Marital Status  1 Never Marr 3 Widowed  | ried 2XMarried                       | 12. Was Decedent<br>Armed Forces<br>1 Tyes 2 1<br>If Yes, Give<br>Year or Dates: | ?            |   | Was Decedent of H<br>f Yes, specify Cuba<br>I□Yes 2□XNo   | ispanic Origin? (S <sub>I</sub><br>an, Mexican, Puert<br>Specify: | pecify Yes or No<br>Rican, etc.) |                          | I4. Race - Am<br>Black, Whi<br>Specify: |  |
| 2 hour   | ted t               |   | 15. Decedent's                       | Education  |              |   | lent's Usual Occup  |   |                                  | 16b. Kir                 | $_{ m Bl}$ nd of Business               | ack<br>/Industry                                 |
| ed within 7<br>/giene.<br>er than "n<br>t, the Medi  | Completed           | Elementary/Seco   | cify only highest g<br>ondary (0-12) | College (1-4or   | 5+)          | life. L                                 | kind of work done of NOT use retired Nitied | ursing .  | Asst.                            |                          | vate                                    |  |
| be filk  | Be                  | 17. Father's Name   |                                      | •  |              |   |   | 18. Mother's Nam  |                                  |                          | Surname)                                |  |
| should<br>bd Mei<br>marke<br>imatic  | 은                   | Thomas  19a. Informant's Na   |                                      | - <del>-</del>   |              | 19b, Mailin                             | g Address (Street a   | Daisy H<br>and Number or Ru                                       |                                  |                          | Town State                              | Zip Code)  |
| indentands: Health artem 27 is   |                     |   | vn Cart                              | hens/Dau   | 120b. Pl     | r 152                                   | 8 Sherwe  | ood Ct.   |                                  | ver,                     |   | 0785   |
| Pages<br>nent of<br>ant: If if   |                     |   | ☐Cremation 3 5☐Other (Spec           | Removal from State   | - 1          | -                                       | natory or other plac<br>Cemete:   | i i   | -2008                            |                          | ,                                       | •  |
| permit.<br>Departr<br>Importa<br>any inj   |                     | 21. Signature Fu  | uneral Service Lic                   | ensee X_   | )            |   |   |   |                                  |                          |   | Funeral Hm                                       |
| 9D = 48 0  |                     | 23a. Part1. Enter t   | the disease, or co                   | mplications that cause   | d the death  |   | 08 W.No   |   |                                  |                          | e, Md                                   | 21201<br>Approximate<br>Interval Between         |
| Physician<br>/Medical  |                     | shock, or hea<br>Immediate Cause (<br>disease or conditio<br>resulting in death)  | art failure. List on<br>(Final       | ly one cause on each li<br>a. unconti  | ne.<br>:011c | ed Dia                                  |   |   |                                  |                          |   | Interval Between<br>Onset and Death<br>6 months  |
| Examiner   |                     | Sequentially list co  | anditions,                           | Due to (or as  | y Ar         | tery                                    | Disease   | >   |                                  |                          |   | 1 year   |
| be executed<br>cian and<br>ourial-transit  | Examiner            | Sequentially list co<br>if any, leading to in<br>cause. Enter Unde<br>Cause (Disease or<br>that initiated events<br>resulting in death) I | injury                               | Due to (or as  | ensiv        | re Car                                  | rdiovasc  | cular Di  | isease                           |                          |   | 1 month  |
| eath certificate be ey<br>attending physician<br>for use as the burial   |                     |   | - (                                  | uroseps  | sis          |   |   |   |                                  |                          |   | 2 weeks  |
| ertifica<br>ling ph<br>e as th   | Med                 | IF FEMALE:  |                                      |  |              |   |   |   |                                  |                          |   |  |
| The law requires that the death certificate be ate has been signed by the attending physicia bage 2 should be detached for use as the bur  | Physician/Medical   | 23b. Was deceden<br>in the past 12<br>1 ☐ Yes 2 ☐<br>9 ☐ Unknown  | months?                              | 23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown                    | 2 Fetal      | death 3                                 | Ectopic pregnancy Other (specify)   |   |                                  | 2                        | 3d. Date of de<br>Month                 | livery<br>Day Year                               |
| w requires that<br>s been signed b<br>should be deta   | by                  | Part II. Other signif   | ficant conditions                    | contributing to death b  | out not resu | Ilting in the un                        | derlying cause give   | en in Part I.   |                                  |                          |   | o the cause of death?                            |
| Physician: The law re this certificate has been real director, page 2 sho  | Completed           |   |                                      |  |              | <del></del>                             |   |   | 24a. Was<br>auto<br>perfe        | psy<br>ormed?            | 24b. Were a prior to death?             | utopsy findings available completion of cause of |
| ician:<br>certific<br>rector,  | Be                  | 25. Was case refer examiner?  |                                      | Hospital:  |              |   | Otho  | 26. Place of Dea  |                                  |                          |   |  |
| ing<br>Affel<br>une  | tion: To            | 1 Yes 2  27. Manner of Deat 1 Natural 2 Accident  |                                      | 28a. Date of Inju  | ıry          | ER/Outpatient<br>28b. Time of<br>Injury | 28c. Injun<br>Work  | 4 □ Nursing H   | ome 5 ☐ Resi<br>28d. Describe    |                          |   | ecify)   |
| To the Hospital or Attend within 24 hours after death. To the Funeral Director: /  | Certification:      | 3 ☐ Suicide<br>4 ☐ Homicide   | 6 Could not determine                | be 280 Place of ini  |              |   | eet, factory, office  |   | 28f. Location (<br>City or To    | Street and<br>wn, State) | Number or R                             | ural Route Number,                               |
| fo the Hospital within 24 hours a fo the Funeral completely filled   | Medical C           | 29a. Certifier<br>(Check only<br>one)   | 1 Certifying F                       | Physician: To the best<br>aminer: On the basis of<br>and manner st               | f examinat   | ion and/or inv                          | estigation, in my or  | pinion, death occu  | rred at the time.                | date and                 | place, and du                           | e to the cause(s)                                |
| To ti<br>withi<br>To ti  | Ř                   | 29b. Signature and  | title of certifier                   | / Jaur   | lis          | w                                       | 29c. License  | 582   | 3                                | 29d. Date                | e signed (Mon                           | th, Day, Year)  relubelt Mi                      |
| 5  |                     | FARF  | HAD J                                | AMAL   | M            | 23a) (Type, F                           | 75 25 L   | Green   | vay C                            | dr                       | Dr. 6                                   | ecubilt MD                                       |
| Sta<br>Registr   |                     | 31. Date filed (Mon.  | FEB 1 5                              | 2008 32. registr   | ar's Signat  | ure                                     | 34  |   | 1                                |                          |   |  |

that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Clark Sanders February 2008 homas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Rosedale Franklin Square H 5. Social Security Number 6. Sex Hospia 8. Date of Birth Dec. 7,1918 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 ☐ M 2 ☐ F Months Days Hours MaryTand 89 Director 220-01**-**6668 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location ıral", or items 23a or 28a-f show | Examiner must be notified at 10d. Inside City Limits 1 ☐Yes 2 No Directo Baltimore Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 U.S.A. 8800 Walther Blvd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 X Yes 2 No WW 11 If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 📉 No þ Specify. Specify: White 3 Widowed 4 Divorced Completed if health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Automotive yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be Elizabeth Graff George Thomas Sanders Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 8800 Walther Blvd. Apt. 1416 Baltimore, Maryland 21234 Department of Health Important: If item 27 Clare Collins Clark (Wife) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ò injury 4 ☐ Donation 5 ☐ Other (Specify) 2-14-08 Baltimore, Maryland 21212 Green Mount Crematory 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 21. Signature of Funeral Service Licens any 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ventricular /Medical Due to (or as a consequence of) Examiner schemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 2 400 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation within 24 hours aren occ...

To the Funeral Director; Aft 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D61785 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 Walther Parhville, MD 21234 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar FEB 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 3. Time of Death William Dykman 2008 5:00 A.M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 303 Jody Way Lutherville Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 1X M 2□ F 9. Birthplace (State or Foreign

Physician

/Medical

Examiner

Funeral

|   | Director  |                   | Usual Residence of Decedent   |   | 85                                 | Yrs.                               |                    |                      | 1                           | 0/19/                               | 1922        | Balt                        | ., Maryland   |  |  |
|---|---|-------------------|---|---|------------------------------------|------------------------------------|--------------------|----------------------|-----------------------------|-------------------------------------|-------------|-----------------------------|---|--|--|
|   | land<br>bw  |                   | 10a. State 10b. County  |   | 10c. City, Tow                     | n or Location                      |                    |                      |                             |                                     |             |                             | 10d. Inside City Limits   |  |  |
|   | Mary<br>-f sh   | tor               | Maryland Baltimore Lutherville  |   |                                    |                                    |                    |                      |                             | 1 □Yes 2 ☑ No                       |             |                             |   |  |  |
|   | r 28a   | Director          | 10e. Street and Number  |   |                                    |                                    | Code               |                      |                             |                                     | 10g. Citi   | izen of What Co             |   |  |  |
|   | h with  | 무                 | 303 Jody Way  |   |                                    |                                    | 21093              | 3                    |                             |                                     | Uni         | United States<br>of America |   |  |  |
|   | deat<br>ms 2  | Funeral           | 11. Marital Status  | 12. Was Decedent                              | Ever in U.S.                       | 13. Was Dece                       | dent of H          | ispanic Ori          | gin? (Specify               | / Yes or No-                        | _OT         | erican Indian,              |   |  |  |
| 9   | after<br>or Ite   | 교                 | 1 ☐ Never Married 2√2 Married   | Armed Forces?<br>1, ☐ Yes 2 ☐<br>If Yes, Give |                                    | 1                                  |                    |                      | n, Puerto Ric               | an, etc.)                           |             | Black, Whit                 |   |  |  |
| 8   | 72 hours after death with the Maryland<br>natural", or Items 23a or 28a-f show<br>dical Examiner must be notified at                          | d by              | 3 ☐ Widowed 4 ☐ Divorced  | Year or Dates:                                |                                    | 1 ☐ Yes                            | 5 <b>X</b> 1 ⋈0    | Specify:             |                             |                                     |             | Specify:                    | white   |  |  |
| 215-0036  |   | ete               | 15. Decedent's Ed<br>(Specify only highest gra  | fucation<br>de completed)                     | 16a.                               | Decedent's Usu<br>(Give kind of wo | al Occup           | ation<br>during mos  | ution   16b. Kind of Busine |                                     |             | nd of Business              | /Industry   |  |  |
| 2   | withir  | 를                 | Elementary/Secondary (0-12)   | College (1-4or                                |                                    |                                    |                    |                      |                             |                                     |             | Airport                     |   |  |  |
| d 21  | e filed within<br>al Hygiene.<br>other than "<br>vent, the Me   | Be Completed by   | 12  <br>17. Father's Name ( <i>First, Middle, Last</i>  |   |                                    | aintenaı                           | ice s              |                      |                             | irst, Middle,                       |             |                             | ·   |  |  |
| ā   | es 1 and 2 should be filed worf Health and Mental Hygie of Health and S7 is marked other it other traumatic event, the                        | To Be             | Rheimhold Dy  |   |                                    |                                    |                    | TO. INIOUTE          |                             | Schae:                              |             | ,                           |   |  |  |
| Maryland  | shound M  | -                 | 19a. Informant's Name/Relationship (  | Type. Print)                                  | 19b                                | . Mailing Address                  | (Street            | and Numbe            |                             |                                     |             |                             | Zin Code)   |  |  |
|   | and 2<br>ealth a<br>n 27 is   |                   | Joyce C. Dykmar   | / wife  |                                    | 303 Jod                            |                    |                      |                             |                                     |             |                             | ·   |  |  |
| <u>o</u>  | of Herm   |                   | 20a. Method of Disposition  |   |                                    | Disposition (Natry, crematory or   | ne of              | (a)                  | Februa                      | 25.7                                |             | cation - City or            |   |  |  |
| Baltimore,  | permit. Pages ' Department of H Important: If Ite any Injury or ot  |                   | 1 ☐ Burial 2 ☑ Cremation 3 ☐<br>4 ☐ Donation 5 ☐ Other ( <i>Specit</i>  |   | Evan                               | s Funera                           | alCha              | ipel                 | 15, 20                      | 08<br>TA                            | For         | est Hil                     | l, Maryland   |  |  |
| <u>=</u>  | permit. Departn Importa any Inju  |                   | 21. Signature of Funeral Service Licer  | see /   | _!                                 |                                    |                    |                      |                             |                                     |             |                             | cion Ctr.,P.A   |  |  |
| ם<br>—  | 8 3 E 8   |                   | Mysto Bx  | 1/2   |                                    | 23                                 | 25 Yo              | ork Ro               | acives<br>bad               | rune:<br>Timon:                     | raı<br>ium. | Marvla                      | nd 21093  |  |  |
|   |   |                   | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only   | olic nons that caused<br>one cause on each li | d the death. Do r                  | not enter the mod                  | le of dyin         | g, such as           | cardiac or re               | spiratory arr                       | rest,       |                             | Approximate<br>Interval Between<br>Onset and Death              |  |  |
|   | Physician   |                   | Immediate Cause (Final disease or condition   | AMER  | ioselen                            | OTIC C                             | ADU I              | VASI                 | um.                         | DISE                                | ne          | <u></u>                     | Onset and Death   |  |  |
|   | /Medical<br>Examiner  |                   | disease or condition resulting in death)  a. AMENOSCIENOTIC CANDIUNTSCOME DISEASE  Due to (or as a consequence of):   |   |                                    |                                    |                    |                      |                             |                                     | 10 9103     |                             |   |  |  |
|   | LAGIIIIICI  | <u>.</u>          | Sequentially list conditions, Coronary Andrry Discuss   |   |                                    |                                    |                    |                      |                             |                                     | 18 yrs      |                             |   |  |  |
| ,   | B jet ig  | nine              | Sequentially list conditions, if any, leading to immediate cause. Entire funderlying Cause (Disease or injury that initiated events  C  |   |                                    |                                    |                    |                      |                             |                                     |             | ·                           |   |  |  |
|   | executed and and all-transit  | Examiner          | that initiated events resulting in death) Last C. Due to (or as a consequence of):  |   |                                    |                                    |                    |                      |                             |                                     |             |                             |   |  |  |
| 00/00   | siciar<br>buri  |                   |   |   | •                                  | •                                  |                    |                      |                             |                                     |             |                             |   |  |  |
| _   | w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit | Physician/Medical |   | .u  |                                    |                                    |                    |                      |                             |                                     |             |                             |   |  |  |
| Š   | th cer<br>endin   | N N               | IF FEMALE: 23b. Was decedent pregnant   | 23c. If yes, outcome                          |                                    | ۰.                                 |                    |                      |                             |                                     | 2           | 23d. Date of del            | ivery   |  |  |
|   | ed for  | sicia             | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4□Pregnant at                                 | 2 □ Fetal death<br>t time of death | 3 □Ectopic pi<br>5 □ Other (sp     |                    |                      |                             |                                     |             | Month                       | Day Year  |  |  |
| ר.  | law requires that the death<br>as been signed by the atter<br>2 should be detached for u  | hy                | 9 Unknown   |   |                                    |                                    |                    |                      |                             |                                     |             |                             |   |  |  |
| ń   | igned<br>be de  | by                | Part II. Other significant conditions of  |   | ut not resulting in                | the underlying c                   | ause give          | n in Part I.         |                             | 23e. Did tol                        | bacco u     | se contribute to            | the cause of death?   |  |  |
| ecolos,   | requi   | ted               | DEMENTA   |   |                                    | <u> </u>                           |                    |                      | [                           | 1 🗆 Ye                              | es 2[       | ]No 3∏Pr                    | obably 4 Unknown  |  |  |
| נו  | E S S   | npleted           | Menoconc  | Mona.   | - Prost                            | ATE                                |                    |                      |                             | 24a. Was a                          |             | 24b. Were au                | Were autopsy findings available prior to completion of cause of |  |  |
|   |   |                   |   |   |                                    |                                    |                    | performed?   death?  |                             | death?<br>1 ☐ Yes                   |             |                             |   |  |  |
| AII   | sician<br>certifi<br>rector   | Be                | 25. Was case referred to medical examiner?  | Hospital:                                     |                                    |                                    | 011-               |                      | of Death (C                 | heck only on                        | ie)         |                             |   |  |  |
| 5   | Phys  | 2                 | 1 Yes 2 No 27. Manner of Death  | 1 ☐ Inpatie                                   | nt 2 ER/Out                        |                                    |                    | 4 🗆 Nur              |                             |                                     |             | Other (Spec                 | cify)   |  |  |
| 5   | dlng<br>h.<br>Afte<br>fune  | ţi                | 1 Action 5 Pending 2 Accident investigation   | (Month, Day                                   |                                    | jury M                             | 8c. Injury<br>Work | at<br>?<br>′es 2 □ N |                             | Describe ho                         | ow injury   | / occurred                  |   |  |  |
| 2   | Atter<br>r deat<br>sctor  | fica              | 3 Suicide 6 Could not be  | 28e. Place of inju                            | ury - At home, far                 |                                    |                    | C3 Z                 |                             | Location (St                        | reet and    | d Number or Ri              | ıral Route Number,  |  |  |
| 5   | al or   | Certification:    | 4 ☐ Homicide  5 ☐ Homicide  4 ☐ Homicide  5 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  7 ☐ Homicide  6 ☐ Homicide  7 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  9 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  2 ☐ Homicide  2 ☐ Homicide  2 ☐ Homicide  2 ☐ Homicide  2 ☐ Homicide  3 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  7 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  9 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  2 ☐ Homicide  2 ☐ Homicide  2 ☐ Homicide  3 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  7 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  9 ☐ Homicide  9 ☐ Homicide  9 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 |   |                                    |                                    |                    |                      |                             | nai riodio riombol,                 |             |                             |   |  |  |
|   | ospit<br>hours<br>uners<br>ily fille  |                   | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  |   |                                    |                                    |                    |                      |                             |                                     |             | stated.                     |   |  |  |
|   | the H<br>tin 24<br>the F<br>the F   | Medical           | one)  | and manner sta                                | ted.                               | Vor investigation                  | , in my op         | oinion, deat         | n occurred a                | at the time, d                      | ate and     | place, and due              | to the cause(s)   |  |  |
| 29b. Signature and title of certifier  29c. License number  DOCZ 8817  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR. VINCENT DIFFERM 7801 YORK ROAD TOUSON  State Registrar  FEB 1 5 2008 |   |                   |   |   |                                    |                                    |                    |                      | 2                           | 29d. Date signed (Month, Day, Year) |             |                             |   |  |  |
|   | -   |                   | - Umunt   | F. 01 100                                     | 4                                  |                                    | DO                 | CZ8                  | 812                         |                                     | 2           | 114/08                      |   |  |  |
|   | 12+1  |                   | 30. Name and address of person who  | ompleted cause of de                          | eath (Item 23a) (1                 | Type, Print)                       | v 0                | ,                    |                             |                                     | M           | 1.                          | 212/2//   |  |  |
|   | Stat  | 0                 | 31. Date filed (Month, Day, Year)   | A2. Registra                                  | ar's Signature                     | y your                             | - Ka               | AL                   | 104                         | SON, V                              | MAR         | YIANO                       | 21209   |  |  |
|   | Star<br>Registra  |                   | FFR 1 5 2008  | Maria   | A A                                | soul                               |                    |                      |                             |                                     |             |                             |   |  |  |
|   |   |                   | I FD T 9 FOOT   |   |                                    |                                    |                    |                      |                             |                                     |             |                             |   |  |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** DUTTON EVELYN DOP M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deat Examiner YATARUBA 108, GWYNN OAK If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Manthal Days | Hours | Min. | (Month, Day, Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 M 2 F Days Director 10c. City. Town or Location 10d. Inside City Limits must be notified at 1 ☐ Yes 2 No Director "natural", or items 23a or by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clothina eamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ba Drive GWYNNOOK, MD21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State HIMWE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune Al Service License M01401 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** erlene Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (coas a consequence of) Examine burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 9□Unknown Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Healin 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 1 Yes 2 No 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier D65046. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

AMBACAVANAN

32. Régistrar's Signature 2008



5311

old court rd,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death EBRUARY 13, 2008 **Physician** Ø5:30AM /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Towson Baltimore 8. Date of Birth
(Month, Day, Year)
9-14-19/8 If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🔀 F 248-30-022 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at 1 XYes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ral", or items 23a or Examiner must be r Funeral Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify 3 Widowed 4 Divorced Completed er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DQ NOT use retired) confary (0-12) College (1-4or 5+) ide event. the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be item 27 Is marked other traumatic ev ၉ 's Name/Relationship (Type. Prot) Daugh 19a. Informan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zle line Balto-MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ R 4 □ Donation \_5 □ Other (Specify) 3 ☐Removal from State 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dwing, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of) Examiner INFLUENZA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760; Physician/Medical the attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performs certificate or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 npatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident Injury 5 Pending investigation death. Il Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29b. Signature and title of certifie 29c. License number 2 29d. Date signed (Month, Day, Year) 08 D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar POH

31. Date filed (Month, Day, Year)

LIM.

DRIVE

TOWSON, MARYLAND

OSLER

7601

2. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |   | ,              | For<br>State<br>Registrar   | State of Maryland  | -  |  | of Health and I<br>Death   | Mental   | Hygier<br>Reg. N  | 0000  | 3 04395   |  |  |
|--|---|----------------|---|--|--|--|--|--|---|---|---|--|--|
| •  | Physici<br>/Medic   |                | 1. Decedent's Name (First, Middle, Last)  | DeLAI  | R, SR.   |  |  | of Death<br>h Cuary                                    | <sup>2</sup> 4, 2008  | 3. Time of Death<br>8:00A M                 |   |  |  |
|  | Examin  |                | 4a. Facility Name (If not institution, give s<br>405 Frankle S  |  |  |  | n, or Location of Death  | 1  | 4   | tc. County of Dea                           | th<br>N/A   |  |  |
| A STATE OF THE PARTY OF THE PAR | Funeral<br>Director   |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthe  |  |  | If Under 1 Y<br>Months D                       | ear If Under 24 Hrs.<br>ays Hours Min.                                 | 8. Date<br>(Mont                                       | h. Dav. Yea   | 9. Bir<br>1960 Ma                           | 9. Birthplace (State or Foreign Country) Maryland |  |  |
| ore, M   | Maryland<br>I-f show<br>fied at   | D-1-image      |   |  |  |  |  |  |   |   | 10d. Inside City Limits                           |  |  |
|  | h with the<br>23a or 28a<br>st be not   | al Director    | 10e. Street and Number 405 F  | rankle Street  |  | 10f. Zip Co                                    | 21225  |  | 10g. (  | Citizen of What Co<br>USA                   | ountry?   |  |  |
|  | be filed within 72 hours after death with the Maryland<br>to Hygiene.<br>Id other than "natural", or items 23a or 28a-f show<br>debet, the Medical Examiner must be notified at | by Funeral     | 11. Marital Status 1  1 □ Never Married 2 □ Married 3 □ Widowed 4 双 Divorced  | 2. Was Decedent Ever in U.S<br>Armed Forces?<br>1                                    |  | Was Decedent<br>f Yes, specify                 | of Hispanic Origin? (S<br>Cuban, Mexican, Puerl<br>No <i>Specify</i> : | pecify Yes<br>o Rican, etc                             | or No-  | 14. Race - Ame<br>Black, Whit<br>Specify: W | e, etc.   |  |  |
|  | within 72 hou<br>iene.<br>than "natura<br>he Medical E  | Completed      | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)   | (Give<br>life. L   | lent's Usual O<br>kind of work d<br>OO NOT use n | ccupation<br>one during most of wor<br>otired) |  | 16b. Kind of Business/Industry  Carpentry Construction |   |   |   |  |  |
|  | be od o   | To Be Co       | 17. Father's Name (First, Middle, Last)   | Harry E. DeL   |  |  | 18. Mother's Nan   |  | iddle, Maide<br>ay Wer  | ,   |   |  |  |
|  | s 1 and 2 should<br>f Health and Mer<br>item 27 is marke<br>other traumatic   |                | 19a. Informant's Name/Relationship ( <i>Typ</i> Shirley M. DeLair   | (Mother)   |  |  | reet and Number or Ru<br>rty St., Ha                                   |  |   |   |   |  |  |
|  | 0 0   |                | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)   | emoval from State  20b. Place Bay  | ace of Disposemetery, crem<br>view (             | sition (Name on<br>natory or other<br>Cremato  | ry, Inc. 2   | Date /9/08   |   | Location - City or timore,                  | Town, State<br>Maryland                           |  |  |
| Balt   | permit. Page<br>Department<br>Important: If<br>any Injury o   |                | 21. Signature of Funeral Ferrie License   | ∘Kevin E Ecke<br>———   | I.v  | Name and A<br>IcCuIIy<br>30 E.                 | ddess of Facility<br>-Polyniak 1<br>Fort Avenue                        | Funera   | al Hon<br>ltimor  | ne, P.A.                                    | 21230   |  |  |
| . Box 68/60,   | Physician<br>/Medical<br>Examiner   |                | Approximate Shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition)  Cardiac Arrest  Approximate Interval Betwee Onset and Deat  |  |  |  |  |  |   |   |   |  |  |
|  |   |                | resulting in death)   | Due to (or as a consequ  |  | al Fail  | ure  |  |   |   |   |  |  |
|  | in A ted  | Examiner       | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury  | Due to for as a consequ  | ence of  |  |  |  |   |   |   |  |  |
|  | ificate be executed<br>g physician and<br>as the burial-transit   | edical Exa     | that initiated events resulting in death) Last  | Due to (or as a consequ  |  |  |  |  |   |   |   |  |  |
|  | ath cert<br>aftending<br>for use a  | Physician/Mec  | IF FEMALE: 23b. Was decedent pregnant in the past 12 minths? 1  |  |  |  |  |  |   | 23d. Date of delivery<br>Month Day          |   |  |  |
| rds, F.  | w requires that the d<br>been signed by the<br>should be detached   | þ              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. |  |  |  |  |  |   |   |   |  |  |
| Vital Records,   | The lar<br>ate has<br>page 2  | Completed      |   |  |  |  | ,  |  | Was an autopsy performed?   | prior to death?                             | utopsy findings available completion of cause of  |  |  |
| VITA   | sician: Th<br>certificate<br>irector, pag   | Be             | 25. Was case referred to medical examiner?  1  Yes 2 No   | ospital:   | 7/0 1  |  | 26. Place of Dea   |  | only one)   |   |   |  |  |
| ō  | ding Phy<br>The After this<br>funeral di  | ition: To      | 27. Manner of Death  1 Matural 5 Pending 2 Accident investigation   | 28a. Date of Injury (Month, Day Year)  | 28b. Time of<br>Injury                           | 28c.   | 4 □ Nursing H<br>Injury at<br>Work?<br>1 □ Yes 2 □ No                  |  |   | 6 □Other (Spe<br>jury occurred              | cify)   |  |  |
|  | To the Hospital or Attenwihin 24 hours after death To the Funeral Director: completely filled in by the   | Certification: | 3 Sulcide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |  |  | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |   |   |  |  |
|  |   | ledical (      | 29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin  | ician: To the best of my know<br>er: On the basis of examinati<br>and manner stated. | /ledge, death<br>on and/or inv                   | occurred at to<br>restigation, in              | ne time, date and place<br>my opinion, death occu                      | , and due to   | o the cause<br>time, date a   | (s) and manner as<br>and place, and due     | s stated.<br>e to the cause(s)                    |  |  |
|  |   | Me             | 29b. Signature and title of certifier 29c. License number 29d. Date signed (I   |  |  |  |  |  |   | Date signed (Mont                           | h, Day, Year)                                     |  |  |
| )  |   |                | muchal 1. 1 de D20327 February  |  |  |  |  |  |   |   |   |  |  |
|  | 1   |                | 30. Name and address of person who cor<br>Michael K. Hise M   | D 840 Holi   | lins S   | treet,   | Baltimore,   | Mary   | land  | 21201                                       |   |  |  |
| H  | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year)<br>FEB 1 5 200  | 32 Registrar's Signat  | ure f  | self.  |  |  |   |   |   |  |  |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            | State of Maryland / Department of Health and Mental Hygiene  1- State Registrar  Certificate of Death  Reg. No. 0 8                                     |                            |   |  |  |                                     |                               |                       |                                      | 04396                      |                                      |  |   |   |
|----------------------------|---|----------------------------|---|--|--|-------------------------------------|-------------------------------|-----------------------|--------------------------------------|----------------------------|--------------------------------------|--|---|---|
|                            | Physici<br>/Medic   |                            | Decedent's Name (First, Middle, Last  | ival-  | ter  | D                                   | myt                           | rov                   | .V                                   | -                          | Date of Dea<br>Month                 | th<br>Day                                      | Year > 008  | 3. Time of Death                                    |
|                            | Examir  |                            | 4a. Facility Name (If not institution, give St. Clizabeth   | Jursing  | Cen  | ter                                 | B                             | a 1+                  | Location of                          | Death<br>UVC               |                                      | 4c. Coun                                       | ity of Death  |   |
|                            | Funeral<br>Director   |                            | 5. Social Security Number 6. Se 217-07-5242  Usual Residence of Decedent  | 7. Age<br>1 M 2 □ F  | (In yrs. last<br>91  | Yrs.                                | If Under 1<br>Months          | Year<br>Days          | If Under 2<br>Hours                  |                            | Date of Birth<br>Month Day<br>07/08/ | 1916   | 9. Birthi<br>Cou<br>Mar   | place (State or Foreign<br>ntry)<br>yland           |
|                            | Maryland<br>I-f ehow  | tor                        | 10a. State 10b. County N/A  |  | 10c. City, To  | own or Loc<br>Balti                 |                               | -                     |                                      |                            |                                      |  | 1   | 10d. Inside City Limits 1  Yes 2  No                |
|                            | h with the<br>3a or 28a<br>It be notifi   | Funeral Director           | 10e. Street and Number<br>3500 Clarenell Ro   | ad   |  | -                                   | 10f. Zip 0                    |                       | 1229                                 |                            |                                      | 10g. Citizen o<br>Unit                         | f What Coul   |   |
| 036                        | 72 hours after death with the Maryland<br>naturel', or iteme 23a or 28a-f ehow<br>dical Examiner must be notified at                                    | b                          | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | 12. Was Decedent E Amyed Forces? 1  Yes 2 N If Yes, Give Year or Dates:            |  |                                     | /as Decede<br>Yes, specif     | 1                     | panic Orig<br>, Mexican,<br>Specify: | in? (Specifi<br>Puerto Ric | Yes or No-<br>an, etc.)              | BI   | ace - Americ<br>ack, White,<br>wify: Whi                          | etc.  |
| 21215-0036                 | 를 고를  | Completed                  | 15. Decedent's Edi<br>(Specify only highest grad<br>Elementary/Secondary (0-12)   |  |  |                                     | and of work<br>O NOT use      | done du<br>retired)   | uring most                           | of working                 |                                      | 16b. Kind of                                   |   | ŕ   |
| .Z pt                      | e filed with<br>Il Hygiene<br>other tha   | Be Co                      | 12<br>17. Father's Name (First, Middle, Last)   |  |  | S                                   | Sign F                        |                       |                                      | 's Name (F                 | irst, Middle,                        | Manu<br>Maiden Suma                            | factu   | ring  |
| Maryland                   |   | ToE                        | Thomas Dmytrow  |  |  |                                     |                               | -                     |                                      |                            | s Dudl                               |  |   |   |
|                            | 12 s<br>h ar<br>7 ts<br>trau  |                            | 19a. Informant's Name/Relationship (T) Barbara Kendrick   |  |  | _                                   |                               |                       |                                      |                            |                                      | r. City or Tow<br>.ge, Ma                      |   | d 21075   |
| Baltimore,                 | t if  |                            | 20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,   |  | _  | of Dispos<br>etery, cremi<br>lowric | _                             |                       |                                      | Date                       |                                      | 20c. Location                                  | ,   | own, State<br>aryland                               |
| Baltii                     | permit, Pag<br>Department<br>Important: i<br>any injury o   |                            | 21. Signature of Funeral Service Licens  WashT-R  |  | ricad  | 22.                                 | Name and                      | Address               | of Facility                          | Hubl                       | oard F                               | uneral   | Home  |   |
| P.O. Box 68760,            | The law requires that the death certificate be executed a Second by the attending physicien and bage 2 should be detached for use as the burial-transit |                            | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only o<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | ications that caused ine cause on each line  | the death. D   |                                     |                               | of dying,             |                                      |                            |                                      |  |   | Approximate Interval Between Onset and Death V-Curs |
|                            |   | Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as a Due to (or as a Due to (or as a Due to (or as a Due to (or as a d. | consequence  | o list                              | true<br>, lla                 | tivi<br>ti'o          | e pu                                 | lmo                        | navy                                 | dist   | easi_   | years<br>Years                                      |
|                            |   |                            | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown                 | 2 ☐ Fetal dea  | ath 3 □E                            | Ectopic pred<br>Other (spec   |                       |                                      |                            |                                      |  | ate of delive   | ery<br>Day Year                                     |
|                            |   | þ                          | Part II. Other significant conditions co  | ntributing to death bu   | t not resulting  | g in the und                        | derlying cau                  |                       | n in Part I.                         |                            |                                      | bacco use co                                   |   | ne cause of death?                                  |
| l Reco                     |   | Completed                  | ehronic Kide  | ney dis-   | ease   |                                     |                               |                       |                                      |                            | 24a. Was a autops perform            | Sy   | . Were auto<br>prior to co<br>death?<br>1 \( \subseteq \text{Yes} | psy findings available mpletion of cause of         |
| Vita                       | ician:<br>certific<br>rector,   | Be                         | 25. Was case referred to medical examiner?  | Hospital:  |  |                                     |                               | Other                 | - 1                                  |                            | heck only or                         | ne)  |   |   |
| Division of Vital Records, | or Attending Phys<br>fter death.<br>birector: After this<br>n by the funeral di   | ation: To                  | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  | 1 Unpatien   | Date of Injury  (Month, Day Year)  28b. Time of Injury  M 1 Yes 2 No  28d. Describe how in |                                     |                               |                       |                                      |                            |                                      |  |   |   |
| Divis                      |   | Certification:             | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of Injur<br>building, etc.  |  |                                     |                               |                       |                                      |                            |                                      | at and Number or Rural Route Number,<br>State) |   |   |
|                            | To the Hospital within 24 hours a To the Funeral Completely filled in   | edical                     | 29a. Certifier 1 Sertifying Phy (Check only one) 2 Medical Exami  | sician: To the best of<br>ner: On the basis of<br>and manner stat                  | examination  | and/or inve                         | occurred at<br>estigation, in | the time<br>n my opii | date and<br>nion, death              | occurred a                 | due to the c<br>at the time, d       | ate and place                                  | nanner as s<br>, and due to                                       | taliad<br>the cause(s)                              |
|                            | To th<br>within<br>To th<br>comp  | Me                         | 29b. Signature and title of certifier   | mins   |  |                                     |                               | License               |                                      |                            |                                      | 9d. Date sign                                  |   |   |
| ,                          | 16 11   |                            | 30. Name and address of person wh   | 1  | ath (Item 23:  | a) (Tvoa P                          | rint)                         | 1)5                   | 1 50                                 | 11                         | -                                    | elmua  | ry 13   | 1227  |
| 014                        | 19  |                            | A 1   | 20 Benso   | /  | renu                                | le,                           | Bal                   | tim                                  | ore,                       | Mary                                 | land   | ( 2   | [25]  |
|                            | Sta<br>Registr  | - 1                        | FFB 1 5 20  | 08 January   | 3 Signature  | A.                                  | sak!                          |                       |                                      |                            |                                      |  |   | /   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** RAYMOND CHARLES DANNETTEL, JR. 7:06 a Feb 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Timonium
If Under 1 Year | If Under 24 Hrs. Baltimore 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours XXM 2□F 79 Director 220-20-2085 July 21,1928 Balto. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2/CNO Director Baltimore White Hall 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2525 Openshaw Road by Funeral 21161 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XX No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Mechanical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Adelaide Bovd Raymond Charles Dannettel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2525 Openshaw Road, White Hall, MD 21161 Barbara Dannettel - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Bunal 2 ☐ Cremation 3 ☐ Removal from State St.Johns Evg.Luth.Ch.Cem2/11/2008 4 Donation 5 Other (Specify) Westminster, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, MD 21212 23a art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician **PNEUMONIA** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA HOSPICE 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Records, P.O. Box 68760 RAYMOND DANNETTEL or Vital To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director; After this Division

State Registrar

29a. Certifier

(Check only one)

29b. Signature and the of certifier

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

TIMONIUM. MD 21093

29d. Date signed (Month, Day, Year)

Division or Vital

Records, P.O. Box 68760 e Hospital or Attending Po 24 hours after death. e Funeral Director: After the letely filled in by the funera

10:10 p.m

DHMH 17 Rev 1/2001

Registrar

29a. Certifier (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD

2300 DULANEY VALLEY RD.

32. gistrar's Signature

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Items 23a Baltimore, Maryland 21215-0036 ŏ "naturel" Peges 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 is marked other then." For State Registrar

**Physician** 

/Medical

Examiner

burial-transit The law requires that the death certificate be executed Records, P.O. Box 68760, as the attending esn jo detached 90 page 2 should certificete Division of Vital fo the Hospital or Attending Physician: this After ! death. Director in by hours after within 24 hours a To the Funeral I

5. Social Security Number Birthplece (State or Foreign Country) **Funeral** 19-80-8059 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 28a-f ehow traumatic event, the Medical Examiner must be notified at 1€Yes 2□No Director 10e. Street and Number ISA Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Maritaf Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed → QO. ack Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) C 17. Father's Name (First, Middle, Last) 1. Mother's Name (First, Middle, Maiden Sumame) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code), 21133 Grinnage 19a. Informant's Name/Relationship (T as Print) 20b. Place of Disposition (Name of cametery, crematory or other place) Jari lin Grinnage Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Pege Department of Important: if any Injury or once. Garrison Forest Cenery 21. Signature of Funeral Service Licensee MO1363 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a11050 ardiac minutes /Medical Due to (or as a consequence of). **Examiner** crea 16013 Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical fF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

1 Pres 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 DER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature in title of certifier 29c. License number February 8, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) north Street 600 Baltimore MORI Wolfe

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

**ORIGINAL** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 16:59 FEBRUARY 10, 2008 HOWARD ALVIN GROSS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Year)
Nov. 12, 1 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days M 2 ☐ F 1924 Maryland 83 Director 219-14-1522 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director Maryland | Harford Joppa 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1211 Old Mountain Road South 21085 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Manufacturer Run Down Recorder 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked i any injury or other traumatic ev 2 <u>Ida Helen Gross</u> John Henry Gross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Audrey E. Gross / Wife 1211 Old Mountain Road South, Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Grdn 2-13-08 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 21. Signature of Funeral Service Licenson 22 Name and Address of Facility McComas Funeral Home, P.A. 1 317 Cokesbury Road, Abingdon, Maryland 21009
23a. P. rt1. Enter the disease, or complication, the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
Approximate Immediate Cause (Final disease or condition resulting in death) a ARTERIOSCLEROTIC CARDIOVASCULAR **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? ∕es 2⊡No 1∐ Yes Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2₩ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 🗌 Yes Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier phyanter FEBRUARY 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 NORTH AVENUE MD MATIN M. ABHYANKAR BEL AIR 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 100 Registrar

DHMH 17 Rev 1/2001

Howard

50016

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "instural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 3altimore, Maryland 21215-0036

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17. Father's Name (First, Middle, Last)

20a. Method of Disposition

DANIEL WHITFORD 19a. Informant's Name/Relationship (Type. Print)

WILLIAM P. GREUTZNER/HUSBAND

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

**Physician** /Medical **Examiner** 

Division or Vital Records, P.O. Box 68760.

23a. Part1. Erfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEP515 disease or condition resulting in death) Due to (or as a consequence of): BILATORAL PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner hed by the attending physician and hetached for use as the hirial-transthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mm ths? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed DEMENTHA To the Hospita. ... within 24 hours after death.

To the Funeral Director: After this certificate

To the funeral director, partition by the funeral director, partition in the funeral director, partition in the funeral director, partition in the funeral director, partition in the funeral director, partition in the funeral director, partition in the funeral director, partition in the funeral director, partition in the funeral director, partition in the funeral director, partition in the funeral director, partition in the funeral director, partition in the funeral director, partition in the funeral director, partition in the funeral director, partition in the funeral director in the funeral dire 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient 1 ☐ Yes 2 ☐ No ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Watural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide 29a. Certifier Medical and manner stated. 29c. License number ATTENDING 29b. Signature and title of certifier 20062239 DR MAN NAING OO 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMAR 17AV

32. Registrar's Signature

600D

31. Date filed (Month, Day, Year)

4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 2/14/2008 CATONSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, (an 21286 8521 LOCH RAVEN TOWSON, MD BLVD. Approximate Interval Between Onset and Death 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

1263 DEANWOOD ROAD

20b. Place of Disposition (Name of cemetery, crematory or other place)

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET UNAVAILABLE

BALTIMORE, MD

20c. Location - City or Town, State

12 2008

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Registrar DHMH 17 Rev 1/2001

State

384

HOSPITAL

|   |   |                             | For<br>State   | • -   |                                  | d / Depa                       | artment of H<br>rtificate of L                 | ealth and <b>N</b>                       | Mental Hyg                                | iene 20                               | 108 04403  |
|---|---|-----------------------------|--|---|----------------------------------|--------------------------------|--|--|---|---------------------------------------|--|
|   |   |                             | Registrar  1. Decedent's Name (First, Middle, La.  | st)   |                                  |                                | timoato or E                                   |  | 2. Date of Dea                            | eg. No.                               | 3. Time of Death                                   |
|   | Physici   |                             | Charlotte M. Hoff  | -   |                                  |                                |  |  | Month<br>02-12-2                          | ,                                     | 1130 A M   |
| <b>)</b>  | /Medic<br>Examin  |                             | 4a. Facility Name (If not institution, give  |   | θr)                              |                                | 4b. City, Town, or                             | Location of Death                        |   | 4c. County o                          |  |
|   | LAGIIIII  | CI                          | Masonic  |   |                                  |                                | Hunt Va  | alley                                    |   | Ba1t                                  | imore  |
|   | Funeral   |                             | Social Security Number 6. S  |   | Age (In yrs.                     | last birthday)                 | If Under 1 Year                                | If Under 24 Hrs.<br>Hours Min.           | 8. Date of Birth<br>(Month, Day           |                                       | Birthplace (State or Foreign Country)              |
|   | Director  |                             | 217-01-3592  | □M 2 <b>X</b> F   | 89                               | Yrs.                           | Months Days                                    | Hours Min.                               | 03-23-1                                   |                                       | aryland  |
| g   | >:-///  |                             | Usual Residence of Decedent  10a. State 10b. County  |   | 10a Cit                          | v. Town or Lo                  | and in a                                       |  |   |                                       | 10d. Inside City Limits                            |
| aryla   | shov  | ٦                           |  |   |                                  |                                |  |  |   |                                       | 1 Yes 27 No  |
| he M  | - 88-1<br>- 1   | ecto                        | Maryland Baltimo   | re  | Coc                              | keysvi                         | 10f. Zip Code                                  |  |   | l0g. Citizen of Wi                    |  |
| with  | a or  | ä                           | 300 International  | Cirolo  |                                  |                                | · ·  |  |   |                                       | nat country:                                       |
| eath  | 18 23   | Funeral Director            | 11. Marital Status   | 12. Was Decede  | nt Ever in U                     | S 13                           | 21030  |  |   | J. S. A.                              | - American Indian,                                 |
| terd  | item<br>in  | Ē                           | 1 Never Married 2 Married  | Armed Force   | es?                              | .0.                            | Was Decedent of Hi<br>If Yes, specify Cuba     | n, Mexican, Puert                        | Rican, etc.)                              | Black                                 | , White, etc.                                      |
| 036<br>urs a  | e i   | þ                           | 3 X Widowed 4 □ Divorced   | 1 Tes 2<br>If Yes, Give<br>Year or Date                 | X:                               |                                | 1 ☐ Yes 2 🙀 No                                 | Specify:                                 |   | Specify:                              | White  |
| d 21215-0036<br>filed within 72 hours after death with the Maryland           | tal Hygiene.<br>d other then "natural", or items 23a or 28a-f show<br>event, the Medical Evandrar must be notified at       | Completed                   | 15. Decedent's Ed<br>(Specify only highest gra   | ducation  |                                  | 16a. Dece                      | dent's Usual Occupa                            | ation                                    | king                                      | 16b. Kind of Bus                      | siness/Industry                                    |
| Z high  |   | du                          | Elementary/Secondary (0-12)  | College (1-4  | or 5+)                           | life.                          | DO NOT use retired                             | )  | ,9  |                                       |  |
| 2 %   | Hygien<br>ther th   | S                           | 12   |   |                                  | House                          | Wife   |  |   | Own Ho                                |  |
| <b>₽</b> ₽  | d d a   | Be                          | 17. Father's Name (First, Middle, Last,  |   |                                  |                                |  |  | ne (First, Middle,                        | Maiden Sumame                         | 9)   |
| aryla<br>should   | l Men<br>varke<br>vatic   | ျ                           | William Meseke   |   |                                  |                                |  | Bertha                                   |   |                                       | 7 0 11   |
| (1)   | h and<br>7 is m<br>raum   |                             | 19a. Informant's Name/Relationship ( Carole Frederick  | Type, Print)<br>(Daught:                                | orl                              |                                | ng Address (Street a                           |  |   |                                       |  |
|   | f Healt<br>item 2<br>other 1  |                             | 20a. Method of Disposition   |   |                                  |                                | Nathan Ha                                      |  | PHOCHIA<br>Date                           |                                       | A 1946U<br>City or Town, State                     |
| Pages   | 0   |                             | 1 ☐ Burial 2X Cremation 3 ☐  |   | ILO I                            |                                | osition (Name of<br>matory or other plac       | 4  |   |                                       |  |
|   | Department<br>Important:<br>any injury o  |                             | * 4 ☐ Donation 5 ☐ Other (Specification of Department of |   | вау                              |                                | Creamtory  2. Name and Addres                  |  | 3-2008                                    |                                       | re, Maryland                                       |
| Balt<br>permit.   | Department Important: If any injury o   |                             | foreste  |   | ,                                | I                              | nc. 610 W                                      | اد<br>I. MacPha                          | ail Rd Be                                 | el Air,                               |  |
|   |   |                             | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only  | plications that cause on each                           | sed the deat<br>h line.          | h. Do not ent                  | er the mode of dyin                            | g, such as cardiac                       | or respiratory arr                        | rest,                                 | Approximate<br>Interval Between<br>Onset and Death |
|   | iysician  | 8.4                         | Immediate Cause (Final disease or condition  | a. 91/  | role.                            | - CUP                          |  |  |   |                                       | Onder and Oddin                                    |
|   | Medical<br>kaminer  |                             | resulting in death)  | Due to (or  | as a conseq                      | uence of):                     |  |  |   |                                       |  |
|   |   | -                           | Sequentially list conditions,  | b. Due to (or   | as a conseq                      | uence of):                     |  |  |   |                                       |  |
| Pet   | Insit   | in in                       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injuried a waret.   | ,   | ,                                | ,                              |  |  |   |                                       |  |
| 60,<br>be executed  | in and<br>ial-tra   | Examiner                    | that initiated events<br>resulting in death) Last  | C. Due to (or   | as a conseq                      | uence of):                     |  |  |   | · · · · · · · · · · · · · · · · · · · |  |
| 0   | ysician and<br>ne burial-transit  | cai                         |  | _ d   | , ,                              |                                |  | ,  |   |                                       |  |
| rifical   | attending physic  | Medi                        | IE ESTANE  |   |                                  |                                |  |  |   |                                       |  |
| <b>Box</b>  | tendir<br>r use   | an/N                        | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome 1 ☐ Live birth                     | me of pregna<br>n 2 ∐ Feta       |                                | Ectopic pregnancy                              |  |   | 23d. Date<br>Mon                      | of delivery<br>th Day Year                         |
| В фе  | by the at<br>stached fo   | Sici                        | in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 4□Pregnan<br>9□Unknow                                   |                                  | eath 5                         | Other (specify)                                |  |   | Wildin                                |  |
| Pat th  | d by  | P.                          | Part II. Other significant conditions of   | ontributing to deat                                     | h hut not res                    | ulting in the u                | nderlying cause give                           | an in Part I                             | 23e. Did to                               | bacco use contri                      | bute to the cause of death?                        |
| dS,   | signed b<br>d be det  | by                          | How. A.L.Z.  | Muto  |                                  |                                |  |  | 1   |                                       | 3 ☐ Probably 4 ☑ Unknown                           |
| S Per   | neeu  | ete                         | Da Dit   | /   |                                  |                                |  |  | 24a. Was a                                | T                                     | Vere autopsy findings available                    |
| VITAL RECORDS, P.O. BOX 68 sician: The law requires that the death certifical | nis certificate has l<br>I director, page 2 s   | Completed by Physician/Medi |  |   |                                  |                                |  |  | autop:<br>perfor                          | sy pr<br>med? de                      | rior to completion of cause of eath?               |
|   | ificate<br>or, pa   |                             | 25. Was case referred to medical   |   |                                  |                                |  | Of Blees of Des                          | 1 ☐ Yes<br>ath (Check only or             |                                       | Yes 2 No   |
| sicia   | s cert  | To Be                       | examiner?  | Hospital: 1 ☐ Inp                                       | atient 2                         | ER/Outpatier                   | nt 3 DOA Othe                                  | 20                                       | ome 5 Resid                               |                                       | r (Specify)  |
| o f   | er thi  |                             | 27. Manger of Death  | 28a. Date of I  |                                  | 28b. Time o                    | The second second                              |  |   | ow injury occurre                     |  |
| <b>o</b> ig   | ath.<br>r: Aft  | atio                        | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation  |   | Day real)                        | rijury                         |  | Yes 2 □ No                               |   |                                       |  |
| DIVISION OF<br>It or Attanding Phy  | racto<br>by th  | Certification:              | 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined   | 286. Place of   | Injury - At he<br>, etc. (Specif | ome, farm, sti                 | reet, factory, office                          |  | 28f. Location (S<br>City or Tow           |                                       | er or Rural Route Number,                          |
|   | rs aft  |                             |  |   |                                  |                                |  |  | þ   |                                       |  |
| e Hosp  | within 24 hours after death.  To the Funeral Diractor: After this certifics completely filled in by the funeral director, I | Medicai                     | 29a. Certifier 1/☐ Certifying Ph<br>(Check only 2 ☐ Medical Examone)   | nysician: To the be<br>niner: On the basi<br>and manner | s of examina                     | wiedge, deat<br>tion and/or in | h occurred at the tim<br>vestigation, in my op | ne, date and place<br>pinion, death occu | , and due to the d<br>rred at the time, o | ause(s) and mar<br>date and place, a  | nner as stated.<br>ind due to the cause(s)         |
| To th   | withii<br>To th   | Me                          | 29b. Signature and title of certifier  | 1   |                                  |                                | 29c. License                                   | number                                   | 2   | 29d. Date signed                      | (Month, Day, Year)                                 |
|   |   |                             | Prit - ful   | no, on  | ^·                               |                                | $\mathcal{P}_{\mathcal{C}}$                    | 71464                                    |   | 2/10                                  | 18   |
|   | 6   |                             | 30. Name and address of person who Robert Liberts, 1   | completed cause of                                      | of death (Item                   | n 23a) (Type,                  | ST Bal   | to, no                                   | 4 Z 12                                    | 24                                    |  |
|   | Sta   |                             | 31. Date filed (Month, Day, Year)  | 1 200   | istrar's Signa                   | ature                          | 70   |  |   | /                                     |  |
|   | Registr   | ar                          | LED T 9 40   | 00  | 1000 10                          | *                              | Red .  |  |   |                                       |  |

State of Maryland / Department of Health and Mental Hygiene

2008 04404

|   |                | 1- For State<br>Registrar  |                    |                           |                      | Certific              | ate of                    | Death      | 7            |                    |            | F                     | Reg. No.     | £_ \         | JUI                 |  |
|---|----------------|--|--------------------|---------------------------|----------------------|-----------------------|---------------------------|------------|--------------|--------------------|------------|-----------------------|--------------|--------------|---------------------|--|
| Physicia  | an/            | 1. Decedent's Name (First, Middl                                   | e,Last)            |                           |                      |                       |                           | -          |              |                    | 2          | . Date of De<br>Month |              | Year         |                     | Time of Death                                  |
| ledical Exami   | ner            | Thomas Hedding   | ger                |                           |                      |                       |                           |            |              |                    |            | February              | 10, 2008     | }            |                     | 1404 hrs                                       |
|   |                | 4a. Facility Name (if not institutio                               |                    | street and num            | nber)                |                       | 4                         |            |              | ocation of         | Death      |                       |              | ounty of D   |                     |  |
|   |                | 251 East Street Antiet   | am                 |                           |                      |                       |                           | Hager      | stown        |                    |            |                       | Wa           | shingto      | n                   |  |
| Funeral   |                | 5. Social Security Number  | 6. Sex             | 7                         | 7. Age (In y         | rs. last bir          | thday)                    |            | r 1 Year     | If Under           |            |                       | ,            | 150          | . Birthpl<br>oreign | ace (State or                                  |
| Director  |                | 217-92-2147  | 1 X                | v1 2 F                    | 36                   |                       | Yrs.                      | Months     | Days         | Hours              | Min.       | 04-02                 | -1971        |              | Count               | <sub>ry)</sub> Maryland                        |
|   | ı              | Usual Residence of Decedent  |                    |                           |                      |                       |                           |            |              | L                  | <u> </u>   |                       |              |              |                     |  |
| any   |                | 10a. State 10b. County   |                    |                           | 10c.                 | City, Town            | or Location               | on         |              | •                  |            |                       |              |              | 10                  | d. Inside City Limits                          |
| P P 9   | _              | Maryland Balti   | mor                | е                         |                      | Balt                  | imor                      | e          |              |                    |            |                       |              |              | 1                   | Yes 2 X No                                     |
| Aaryland 28a-f show   | 용              | 10e. Street and Number   |                    |                           |                      |                       |                           | 10f. Zip   | Code         |                    |            |                       | 10g. Citizen | of What      | Country             | ?  |
| th the Maryland 23a or 28a-f sho  | Director       | 6618 Fairdel A   | We.                |                           |                      |                       |                           | 21         | 206          |                    |            |                       | U.           | S.A.         |                     |  |
| vith the s 23a  | <u>=</u>       | 11. Marital Status   |                    | 12. Was Dece              | edent Ever           | in U.S.               | 13. Was                   |            |              | anic Origi         | n? (Spe    | cify Yes or N         | 0- 14        | Race - A     | mericar             | n Indian, Black,                               |
| ath v   | Funeral        | 1 Never Married 2 X Ma   |                    | Armed For                 | rces?                |                       |                           |            |              |                    |            | tican, etc.)          |              | White, et    | tc.                 |  |
| ter de  |                | 3 Widowed 4 Div  | orced I            | 1 Yes<br>f Yes, Give Year | 2 <b>X</b>           | No                    | 1                         | Yes 2      | X No         | specify:           |            |                       | Sp           | ecify: V     | Whit                | e  |
| urs af  | l by           | 15. Decedent's Education (Spe                                      |                    | or Dates:                 |                      | d) 16a.               | Decedent                  | 's Usual   | Occupatio    | n (Give ki         | ind of wo  | rk done               |              | of Busine    |                     |  |
| 2 ho  | ě              | Elementary/Secondary (0-12)  |                    | College (1-               | 4 or 5+)             |                       | during mo                 | st of wor  | king life. D | TON OC             | se retire  | ed)                   | 1            |              |                     |  |
| than edics  | Completed      | 8  |                    |                           |                      | ]                     | Labor                     | er         |              |                    |            |                       | Ro           | ofing        | 3                   |  |
| ed wii  | 등              | 17. Father's Name (First, Middle,                                  | Last)              | _                         |                      |                       |                           |            | 18           |                    |            | First, Middle         |              | rname)       |                     |  |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica  | Be             | Bruce D. Hedd:   | inge               | r, Sr.                    |                      |                       |                           |            |              | He                 | Len :      | Berger                |              |              |                     |  |
| 21<br>buld I<br>I Mer<br>ic ev  | ၉              | 19a. Informant's Name/Relations                                    | hip (Typ           | e, Print )                |                      | 19                    | b. Mailing                | Address    | (Street      | and Numb           | per or Ru  | ıral Route Nu         | ımber, City  | or Town, S   | State, Z            | ip Code)                                       |
| MD<br>nd 2 sho<br>alth and<br>m 27 is   |                | Robin Bortner  | (Si                | ster)                     |                      | 1                     | 602                       | Lanc       | elot         | Lane               | e B        | el Air                | MD 2         | 1015         |                     |  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. |                | 20a. Method of Disposition   |                    | 7                         |                      | Ob. Place             | of Disposi<br>tory or oth |            |              | etery,             |            | Date                  | 20c. Loc     | cation - Cit | ty or To            | wn, State                                      |
| nor nor nor nor nor othe  |                | 1 Burial 2 X Cremation   | -                  | ∫ Removal fro             |                      | Bayvi                 | -                         |            |              |                    | 02-        | 15-200                | g Balt       | timor        | e.                  | Maryland                                       |
| Baltimore,<br>permit. Pages I an<br>Department of Hee<br>Important: If ite<br>injury or other tr  |                | 4 Donation 5 Other Sp<br>21. Signature of Funeral Service          |                    | <br>e.                    |                      | bay va                |                           |            |              | of Facility        |            |                       |              |              |                     | of BelAir                                      |
| Liting De Paragonia   |                | Russin G. 4  | 12                 | lleu                      |                      |                       | In                        | c. 6       | 10 W         | . Mac              | oen<br>Pha | imunek<br>il Rd       | Bel A        | ir M         | nome<br>D 21        | .014   |
| Physician   |                | 23a. Part I. Enter the disease, or                                 | compli             | cations that ca           |                      | eath. Do n            |                           |            |              |                    |            |                       |              |              |                     | Approximate Interval                           |
| /Medical  |                | failure. List only one cause                                       |                    | ine.<br>Implicat          | tiona                | of nor                | ootie                     | inters     | a cost a     | ů.                 |            |                       |              |              |                     | Between Onset and<br>Death                     |
| xaminer   |                | Immediate Cause (Final disease<br>or condition resulting in death) |                    | ue to (or as a            |                      |                       | COLIC                     | 111002     | deal. E      |                    |            |                       |              |              | $\neg$              |  |
| -   |                | Sequentially list conditions,                                      | b                  |                           |                      |                       |                           |            |              |                    |            |                       |              |              | _                   |  |
|   | Examiner       | if any, leading to immediate                                       | D                  | ue to (or as a            | consequen            | ice of):              |                           |            |              |                    |            |                       |              |              |                     |  |
|   | ä              | (Disease or injury that initiated                                  | c.                 | ue to (or as a            | consequen            | ice of):              |                           |            |              |                    |            |                       |              |              | -                   |  |
| ansit   |                | events resulting in death) Last                                    | d.                 | (                         |                      | ,-                    |                           |            |              |                    |            |                       |              |              | - 1                 |  |
| 3760,<br>ficate be executed<br>g physician and<br>s the burial - transit  | /Medical       | X UNPENDED   |                    | AMENDED-                  | 20- £                | M                     | r -077                    | 2/6/       | ′∩o mm       |                    |            |                       |              |              |                     |  |
| <b>60,</b> tte be hysici  | Jed            | IF FEMALE:   |                    | #23a,27                   | , ZOaTI              | per M                 | E,go//                    | 3/0/       | 06 11        |                    | _          |                       | 23d. [       | Date of de   | elivery             |  |
| an 00 an  | Z              | 23b. Was decedent pregnant in the past 12 months?                  | ie                 | 1 Live bit                |                      |                       |                           | al death   | 3            | Ectopic            | pregnar    | ісу                   |              | onth         |                     | y Year   |
| Box 68760,<br>e death certificate be<br>the attending physic  | ::             |  |                    |                           | ant at time          | -6 -141.              |                           | ner (Spe   |              |                    |            | <u></u>               |              |              |                     |  |
| Box 687  ne death certific  the attending perfective as the   | Physiciar      |  | known              | 9 Unknow                  | -SHE-24E-3-          |                       |                           |            |              |                    |            |                       |              |              |                     |  |
| P.O.  | by P           | Part II. Other significant condit                                  | ions (             | ontributing to            | death but            | not resultir          | ng in the u               | nderlying  | cause giv    | ven in Pai         | rt I.      |                       |              |              | _                   | e cause of death?                              |
| b, P.C.   | 8              |  |                    |                           |                      | <del></del>           |                           |            |              |                    |            | 1 Y                   | es 2         |              |                     | oly 4 🗹 Unknown                                |
| ords,   | Completed      |  |                    |                           |                      |                       |                           |            |              |                    |            | 24a. Wa<br>aut        | s an<br>opsy |              |                     | psy findings available<br>npletion of cause of |
| ecc<br>he lav<br>te ha  | Ĕ              |  |                    |                           |                      |                       |                           |            |              |                    |            |                       | formed?      |              | ath?  Yes           | 2 No   |
| tal Rection: The certificate  |                | 25. Was case referred to medica                                    |                    |                           |                      |                       |                           |            | 26.Place o   | of Death (         | Check o    |                       |              |              |                     |  |
| of Vital Records, g Physician: The law requir wher this certificate has been s meral director, page 2 should i  | o Be           | examiner?  |                    | spital:                   | npatient 2           | 2 V ER/0              | outpatient                |            |              | Other <sub>4</sub> | 1          | Home 5                | Residenc     | e 6          | Other:              |  |
| n of \<br>ing Phy<br>After th<br>funeral o  | -              | 1 Yes 2 No 27. Manner of Death                                     |                    | 28a. Date of              |                      |                       | Time of Ir                |            | 28c. Injury  | at Work            | ?          | 28d. Describ          | e how injury | occurred     |                     |  |
| ion (tending eath.  | . <u>e</u>     | 1 Natural 5 Pend   | ling               |                           | Day,Year)<br>/9/2008 | 2 1                   | d 10:0                    | n          | 1 Ye         | es 2 X             | No         | unknow                | 1            |              |                     |  |
| Division tal or Attendi rs after death. al Director: A  | icat           |  | stigation          | 28e Place                 |                      |                       |                           |            |              |                    |            |                       |              | Number       | or Rura             | Route Number, City                             |
| Divi  | Certification: | dete   | d not be<br>rmined | <b>9</b>                  | found                |                       |                           |            |              |                    |            | RCT° 1870             | State)       | urv Ro       | i Hag               | gerstown, MD                                   |
| 12 E S 15   |                | 29a. Certifier   | rveicia            | n: To the best            |                      |                       |                           |            | time date    | e and nla          |            |                       |              |              |                     |  |
| To the Hos<br>within 24 h<br>To the Fur<br>completely   |                | one) 2 ✓ Medical Exa   | miner:             | On the basis o            | of examinat          | ion and/or            | investigati               | ion, in my | opinion,     | death occ          | curred at  | the time, da          | te and place | , and due    | to the              | cause(s)                                       |
| To To con   | Medical        | 29b. Signature and title of certifie                               |                    | and manner sta            | ated                 |                       |                           |            | . License    |                    |            |                       |              |              |                     | h, Day,Year)                                   |
|   |                | his h  | Ú.                 | MIT                       |                      |                       |                           |            | O.C.N        | 1.E.               |            |                       | Febru        | ary 11,      | 2008                |  |
|   |                | 30. Name and address of person                                     | who co             | mnleted caus              | e of death           | (Item 23a)            |                           | -          |              |                    |            |                       |              |              |                     |  |
| _   |                |  |                    | edical Exam               |                      | (11em 23a)<br>111 Per |                           | t, Balti   | more, N      | /ID 212            | 01         |                       |              |              |                     |  |
|   | ate            |  |                    | 26                        | gistrar's Si         |                       | •                         | 4 .        | -            |                    |            |                       |              |              |                     |  |
| Regis   |                | 31. Date filed (Month, Day, Year) FEB 1 5                          | ZUUÖ               | Sale                      | 128.0 2              | St. A                 | 304                       |            |              |                    |            |                       |              |              |                     |  |

|          |   |                | For<br>State<br>Registrar  | State of Marylan   | d / Dep<br><i>Ce</i>       | artment of H<br>ertificate of L                              | lealth and M<br>D <i>eath</i>              |  | giene 20                              | 08 04405   |
|----------|---|----------------|--|--|----------------------------|--|--|--|---------------------------------------|--|
|          | Physicia  |                | 1. Decedent's Name (First, Middle, Last)   | Richard L. H   | otali                      | ng, Sr.  |  | Date of Dea     Month                    | th Day                                | 3. Time of Death Year 2008 9:45 A M                                |
|          | /Medic<br>Examin  |                | 4a. Facility Name (If not institution, give s  |  |                            |  | Location of Death                          | 10010                                    | 4c. County of                         |  |
|          | LAGIIIII  | .ar            | Genesis Heritage   | Meridian Ctr   | •                          | Dune   | dalk                                       |  |                                       | Baltimore  |
| 6        | Funeral<br>Director   |                | 5. Social Security Number 6. Sex 1 № 1   | 7. Age (In yrs. I  | ast birthday<br>Yrs.       | ) If Under 1 Year<br>Months Days                             | If Under 24 Hrs.<br>Hours Min.             | 8. Date of Birth<br>(Month, Day<br>April | , Year)<br>5,1922                     | 9. Birthplace (State or Foreign Country) New York                  |
| 8        | p.  |                | Usual Residence of Decedent  | T. a.  |                            |  |  |  |                                       |  |
|          | arylar<br>show<br>d at  | _              | 10a. State 10b. County   | 10c. City  | , Town or L                | ocation  |  |  |                                       | 10d. Inside City Limits 1 ☐ Yes 2 XNo                              |
|          | Ba-f  | Director       |  | timore   |                            | Dunc   | dalk                                       |  |                                       |  |
|          | a or 2  | ä              | 10e. Street and Number   | 1  |                            | 10f. Zip Code  | 01000                                      | 1  | 10g. Citizen of Wh                    | d States   |
|          | eath  | era            | 2741 Moorgate Ro   | a.c.<br>I2. Was Decedent Ever in U.  | S 13                       | Was Decedent of Hi   | 21222                                      | acify Ves or No-                         |                                       | - American Indian,   |
| 30       | be filed within 72 hours after death with the Maryland stal Hygiene.  Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral     | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced   | Armed Forces?  1   | 0. 10.                     | Was Decedent of Hi<br>If Yes, specify Cuba<br>1 ☐ Yes 2 ☒ No | Specify:                                   | Rican, etc.)                             | Black, Specify:                       | White, etc.  |
| 2-0036   | 2 hou<br>atura<br>cal E   | ed             | 15. Decedent's Educ  | eation   | 16a. Dece                  | edent's Usual Occup  | ation                                      | T  | 16b. Kind of Busi                     |  |
| 212      | within 7;<br>iene.<br>than "n<br>the Medi   | Completed      | (Specify only highest grade<br>Elementary/Secondary (0-12)   | completed) College (1-4or 5+)  | (Give                      | e kind of work done o<br>DO NOT use retired                  | luring most of work<br>)                   | ing                                      |                                       | _  |
| 7        | e filed wall Hygier other the   |                |  | 4 Years  | Pu                         | rchasing l   |  | /F:                                      | Manufac                               |  |
| and      | ould be fi<br>Mental H<br>arked otl<br>atlc ever  | o Be           | 17. Father's Name (First, Middle, Last)  Elmer Hotaling  |  |                            |  | 18. Mother's Name<br>Viola                 | Whispl                                   | · · · · · · · · · · · · · · · · · · · | )  |
| <u></u>  | 2 should be<br>and Menta<br>is marked<br>raumatic ev  | ၉              | 19a. Informant's Name/Relationship (Type   | De. Print) Wife  | 19b. Mail                  | ling Address (Street a                                       |  |  |                                       | tate. Zip Code)  |
| ME.      | E # Z E   |                | Mrs. Bernadine M.  |  |                            | Moorgate   |  |  | Maryland                              |  |
| ore      | of Hez<br>of Hez<br>if item<br>or othe  |                | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re   | emoval from State  | emetery, cre               | osition (Name of<br>ematory or other place                   | e) ;                                       | Date                                     | 20c. Location - C                     | city or Town, State  |
| Ε        | . Pages<br>tment of I<br>tant: If its<br>jury or o  |                | 4 ☐ Donation 5 ☐ Other (Specify)   | Entombment G   |                            | of Faith (   |  |  |                                       | ore, Maryland  |
| Palt     | permit. Pages<br>Department of<br>Inportant: If i<br>any Injury or  |                | 21. Signature of Funeral Service License   |  | 2                          | Dice new 22 Wise   |  |  |                                       |  |
|          | Physician   |                | 23a. Part1. Enter the disease, or complication shock, or heart failure. List only on immediate Cause (Final disease or condition | TRIPOLITA  | JII                        | -X 1 / N/  | AIB  | 4001                                     | DING                                  | Approximate<br>Interval Between<br>Onsets not Ceath                |
|          | /Medical  |                | disease or condition resulting in death)   | Due to (or as a consequence of the Consequence of t | uence of):                 | HC CAO   | DICOL A                                    | 201111                                   | ~                                     | 25011(3  |
|          | Examiner  | _              | Sequentially list conditions, if any, leading to immediate   | Punto for son a consecuti  | I=KO                       | IIC CAR  | DION HS                                    | CULA                                     | CEAR                                  | 207 FARS   |
| /        | uted<br>d<br>ansit  | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events   | Due to (of as a consequ  | derice or,                 |  |  | 1)(                                      | SHO                                   |  |
| o<br>O   | ficate be execui<br>physician and<br>s the burial-trar  |                | resulting in death) Last   | Due to (or as a consequ  | uence of):                 |  |  |  |                                       |  |
| 08/00    | icate t<br>physic<br>s the b  | edical         | d  |  |                            |  |  |  |                                       |  |
| J. BOX ( | attending<br>for use a  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 3c. If yes, outcome pf pregna<br>1□Live birth 2□Feta<br>4□Pregnant at time of d<br>9□Unknown   | I death 3                  | □Ectopic pregnancy<br>□ Other (specify)                      |  | _  | 23d. Date<br>Mont                     | ,  |
| S, 7.    | w requires that the de<br>been signed by the s<br>should be detached  | by Phy         | Part II. Other significant conditions con  | tributing to death but not resu  | ulting in the              | underlying cause give  | en in Part I.                              | 23e. Did to                              | bacco use contrib                     | oute to the cause of death?  |
| ecoras   | require<br>een sig  | ted !          | ACUILIRE   | MULFI  | 1166                       | ICE  |  | 1 🗆 Y                                    | es 2 No 3                             | B Probably 4 □Unknown  |
| r        | The lasate has  | Completed      |  |  |                            |  | <u> </u>                                   | 24a. Was a<br>autop<br>perfor<br>1  Yes  | sy pr<br>rmed? de                     | ere autopsy findings available for to completion of cause of eath? |
| N I I a  | clan:<br>ertific  | Be (           | 25. Was case referred to medical examiner?   |  |                            |  | 26. Place of Deat                          | h (Check only o                          | ne)                                   |  |
| 5        | > .ºº 0   | ပ္             | 1 163 2 4110   |  | ER/Outpatie                |  | 4 Nursing Ho                               |  | lence 6 Other                         |  |
|          | ng<br>offee   | ion            | 27. Mann of Death  1   | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time<br>Injury        | Worl   | y at<br>⟨?<br>Yes 2 □ No                   | 28d. Describe h                          | ow injury occurre                     | d  |
| DIVISION | To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral                                       | Certification: | 2 Accident 3 Suicide 4 Homicide  | 28e. Place of injury - At ho<br>building, etc. (Specify  | me, farm, s                |  |  | 28f. Location (S<br>City or Tow          |                                       | r or Rural Route Number,   |
|          | e Hospita<br>24 hours<br>e Funera<br>etely filler   | ledical C      | 29a. Certifier 1 Certifying Phys   | sician: To the best of my kno<br>ner: On the basis of examina<br>and manner stated.  | wledge, dea<br>tion and/or | ath occurred at the tir<br>investigation, in my o            | ne, date and place,<br>pinion, death occur | and due to the ored at the time,         | cause(s) and man<br>date and place, a | nner as stated.<br>nd due to the cause(s)                          |
|          | To the Hos within 24 h To the Fur completely  | Me             | 29b. Signature and title of continer   | Lingh N  | 1.                         | 29c. Libenso   | e number.                                  | 0 7                                      | EBRUAL                                | (Month, Day, Year)<br>RY (2,2008                                   |
| 1        | X1  |                | 30. Name and afterest of person who so   | millered cause drebath (ter  | 23а Туре                   | , Pro3410  | -ARI                                       | TCHI                                     | EHO                                   | GHWAY,   |
|          | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year) FEB 1 5 2008   | 32. Registrar's Signa  | cont                       | MITE   | 741  | (D)                                      | 2 (22                                 | -5-  |

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 11, 2008 Month **Physician** Hartnett 10:45AM February Marjorie Roslie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6410 Dillon Street N/A Baltimore City 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Days 215-34-8900 1 M 2 F Months Hours Oct. Director 28,1936 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MXYes 2 No Maryland Baltimore City N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6410 Dillon Street 21224 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 232 If Yes, Give Year or Dates: 1x Never Married 2 Married 2x No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Distribution Elementary/Secondary (0-12) College (1-4or 5+) Distributor Center 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mildred Smith John Hartnett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Sarzynski (Sister) 1217 Steelton Ave. Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 2/13/2008 Towson, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21. Signature of Funeral Service Licensee I Home of Dundalk, Inc. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Atherosclerotic Cardiovascular Disease Dyears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No 4☐Pregnant at time of death
9☐Unknown Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Dabeles Mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed History of Rheumanc Fever 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Atrial Fibrillation 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 12 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOO 578 66 February 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21224 Hopkins Baltimore MD Bayview Gicle 31. Date filed (Month, Day, Year) 82. Registrar's Signature State Registrar 2008 FEB 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 1/2001

|              |  |                 | - State<br>Registrar  | e of Maryland  |                            | artment o  |                          |                       |  | giene<br>Reg. No. | 2008                                     | 3 04407  |
|--------------|--|-----------------|---|--|----------------------------|--|--------------------------|-----------------------|--|-------------------|--|--|
|              | Physic<br>/Medi  |                 | 1. Decedent's Name (First, Middle, Last)  Scott   | William  | Han                        | nan  |                          |                       | 2. Date of Dea<br>Month<br>Februa      | Day               | Year .0, 200                             | 3. Time of Death  8 5:25 P                                     |
|              | Examir   |                 | 4a. Facility Name (If not institution, give street and 7808 Kentley Road  |  |                            | Dı   | wn, or Location          |                       |  | 4c. (             | County of Deat                           |  |
|              | Funeral<br>Director  |                 | 5. Social Security Number 216-02-4638 6. Sex Usual Residence of Decedent  | 7. Age (In yrs. la   | Yrs.                       | If Under 1 Months D                              | Year If Und              | der 24 Hrs.<br>S Min. | 8. Date of Birt<br>(Month, Day<br>June | y, Year)          | Co                                       | hplace (State or Foreign<br>untry)<br>ryland                   |
|              | ne Maryland<br>8a-f show<br>otiffed at   | Director        | 10a. State 10b. County  Maryland Baltimore  |  | , Town or Lo               |  |                          | ındalk                |  |                   |  | 10d. Inside City Limits - 1 ☐ Yes 2 XNo                        |
|              | ath with the 23a or 2 ust be no  | ral Dire        | 10e. Street and Number 7808 Kentley Road  |  |                            | 10f. Zip Co                                      | 21222                    |                       |  | Un                | en of What Co<br>ited St                 |  |
| 980          | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | by Funeral      | 1 Never Married 2 Married 1 If Ye   | Decedent Ever in U.Sed Forces?<br>Yes 2 \ No<br>s, Give<br>or Dates:   |                            | Was Deceder<br>If Yes, specify<br>1 ☐ Yes 2🏖     |                          |                       | ecify Yes or No-<br>Rican, etc.)       |                   | 4. Race - Ame<br>Black, Whit<br>Specify: |  |
| 1215-0       | within 72 ho<br>iene.<br>than "natur<br>he Medical.  | Completed       | 15. Decedent's Education (Specify only highest grade completed in the complete state of | ge (1-4or 5+)  | (Give<br>life. i           | dent's Usual (<br>kind of work (<br>DO NOT use ( | done during n<br>etired) | nost of work          | ing                                    | 16b. Kin          | d of Business                            | Industry   |
| 77           | should be filed within<br>and Mental Hygiene.<br>s marked other than<br>umatic event, the M  | To Be Co        | 17. Father's Name (First, Middle, Last) Charles Hannan  | its  |                            | JEGUDIC  | <del></del>              |                       | e (First, Middle,<br>ally An           | Maiden S          | ,  |  |
|              | Health and I sho Health and Iem 27 is matcher traums   |                 | 19a. Informant's Name/Relationship (Type. Print<br>Mr. Charles Hannan (I  | Tather)  |                            | ng Address (S<br>3 Kentl                         |                          |                       | al Route Numbe<br>ndalk ,              |                   |  | Zip Code)<br>21222   |
| Baltimore,   | 0 0  |                 | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Denation 5 ☐ Other (Specify)  | rom State Ce   | Lawr                       | sition (Name<br>matory or othe<br>n Cemet        | erplace)<br>.ery         | 2/14                  | ) 2008                                 | Bal               |  | Maryland   |
| Ball         | permit. Pag<br>Department<br>Important: I<br>any Injury o<br>once.   |                 | 21. Signature of Maneral Service Lipensee   | rell   |                            | 7922 Wi  | se Ave                   | eDu                   | Home of<br>ndalk,                      | Mary              |  | Inc.<br>21222  |
|              | Physician /Medical sician and panal-transit pnual-transit  | dical Examiner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.  | e to (or as a consequence to (or a))). | ence of):                  | 1s G v   |                          |                       |  | rrest,            |  | Approximate Interval Between Onset and Death  MILLIPES  Syruls |
| P.O. Box 687 | The law requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit  | Physician/Medic | in the past 12 months?  | s, outcome pf pregnar<br>live birth 2 □ Fetal<br>Pregnant at time of de<br>Jnknown   | death 3                    | Ectopic preg                                     |                          |                       |  | 2                 | 3d. Date of de<br>Month                  | ivery<br>Day Year  |
| rds, P       | w requires that<br>been signed b<br>shouid be deta   | by              | Part II. Other significant conditions contributing  | to death but not resul   | Iting in the u             | nderlying caus                                   | se given in Pa           | art I.                | 23e. Did to                            |                   | 1  | the cause of death?  |
|              |  | Completed       | <u> </u>  |  |                            |  |                          | <del> </del>          |  |                   |  | utopsy findings available completion of cause of               |
| Vita         | Physician: Th<br>this certificate<br>ral director, pag   | Be              | 25. Was case referred to medical examiner?  Hospital:   |  |                            |  | 26. PI<br>Other:         | ace of Death          | (Check only o                          | n(e)              |  |  |
| ō            | g Phys<br>er this<br>eral di   | . To            | 27. Manner of Death 28a. I  | Date of Injury   | R/Outpatier<br>28b. Time o |  | Injury at Work?          | Nursing Ho            | me 5 Resid                             |                   | Other (Spe                               | cify)  |
| Division     | l or Attending I<br>after death.<br>Director: After<br>in by the funer   | Certification:  | 2 Accident investigation 3 Suicide 6 Could not be determined  | Month, Day Year) Place of injury - At hor  | Injury<br>ne, farm, str    | М  | 1   Yes 2                | □No                   | 28f. Location (S                       | Street and        |  | ural Route Number,   |
| Ď.           | e Hospital or At<br>24 hours after d<br>e Funera Direct<br>letely filled in by   | al Cert         | 29a. Certifier TC Certifying Physician: T   | ouilding, etc. (Specify)   | vledge, deat               | h occurred at                                    | the time, date           | and place,            | and due to the                         | cause(s)          | and manner a                             | s stated.  |
|              | To the Hospita within 24 hours To the Funeral completely filled  | Nedical         |   | manner stated.   | ion and/or in              |  |                          |                       |  |                   |  |  |
|              | viii<br>con  | Σ               | 29b. Signature and title of certifier   | Z, MD  |                            |  | F73                      |                       |  | - /               | signed ( <i>Mon</i> i                    |  |
|              | H Sta  | ate.            | 30. Name an address of person who completed  DAVID MCS. VIAIS  31. Date filed (Month, Day, Year)  | cause of death (Item   | 23a) (Type, 0.753          | Print)   | Rea                      | 似井                    | 225 L                                  | ITE.              | Rvius                                    | MD 21093   |

State Registrar

DAVID MCG WIMIS

31. Date filed (Month, Day, Year) FEB 1 5 2008

# **Physician** /Medical Examiner **Funeral** Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10a State Director Maryland 10e. Street and Number Funeral 11. Marital Status Baltimore, Maryland 21215-0036 þ Completed 12 Be ဂ္ ortant: If It injury or o **Physician** disease or condition resulting in death) /Medical Examiner

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 9, February 2008 7:26 P M Grace Mary Hubbe 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center @ GBMC Towson 8. Date of Birth (Month, Day, Year) Nov. 26, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days Hours 1 ☐ M 2 🕱 F 1950 Maryland 215-52-5357 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🛣 No Harford Belcamp 10f. Zip Code 10g. Citizen of What Country? 1238 Caldwell Ct. North 21017 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 No 1 ☐ Yes 2 ☑ No Specify. Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincent Leonard Nardone Clara Tenni Waters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vernon E. Hubbe / Spouse 1238 Caldwell Ct. North, Belcamp, MD 21017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Darlington Cemetery 2-13-08 Darlington, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MENINGITIS WEEKS Due to (or as a consequence of): ORBITAL CELLULITIS WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner SINUSITIS Due to (or as a consequence of Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 2 LUPUS 1 ☐ Yes 2 📉 No 3 Probably 4 Unknown Completed DIABETES 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE ို 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D64395 FEBRUARY 10, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 NCHARLES ST, SUTTE 209 BALTIMOREIMD 2204 DANIELLE DOBERMAN, MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

burial-tran Division or Vital Records, P.O. Box 68760, physician the for use led by the a detached f page 2 s To the Hospital or Attending Physician: After this funeral 24 hours after death Funeral Director:

State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** James Haunie February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Bayview Medical Center Johns Hopkins
5. Social Security Number 1timore 7. Age (In yrs. last birthday) If Under 24 Hrs Hours Min 8. Date of Birth (Month, Day, Year) If I Inder 1 9. Birthplace (State or Foreign **Funeral** Months Days 14□ M 2 □ F 84 Maryland Director 212-18-9667 June 3, 1923 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD N/A 1 ☐ Yes 2 ☐ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 329 S. Newkirk Street 21224 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11 Marital Status Black. White, etc. 1 DYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Security Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosser Haynie P Mary Frederick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Haynie- Wife 329 S. Newkirk Street Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery 2/15/08 Baltimore, Maryland 22. Name and Address of Facility Charles S. Zeiler & Son 21. Signature of Funeral Service Licensee 6224 Eastern Avenue Baltimore, MD 21224 Approximate Interval Between Onset and Death 23a Part1 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. , or heart Immediate Cause (Final disease or condition resulting in death) **Physician** Renal Failure weeks /Medical Due to (or as a consequence of): Examiner to Pneumonio secondary Sequentially list conditions, if any, balling to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the for use as IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 4 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 28 No 2 □ No Physician: 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Y No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Natural 5 Pending Injury 1 Yes 2 No 4 hours after death. •uneral Director: A ely filled in by the fu death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer February 11, 2008 RES- 600 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Jose Luis Lopezy M. D. 4940 Eastern Ave. Baltimera, MD

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32 egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Gordon George Jones 9:00 AM February 14,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oak Crest Parkville Baltimore Co. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Director Feb. 17,1919 220-05-7307 88 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2\n\timeNo Directo Parkville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? a or 8800 Walther Blvd. Apt. 3609 United States 'natural", or Items 23a 21234 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc filed within 72 hours after 1 ☐ Yes ⊉★No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify 2 3 ☐ Widowed 4 ☐ Divorced White Completed er than "natur the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) th and Mental Hygier
It is marked other the 6 Years School Teacher Baltimore County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frieda Schloda George Henry Jones ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 7708 North Pt. Creek Road Edgemere, MD Gloria Strasbaugh 21219 (Friend) injury or other If Item Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Lawn Cemetery 2/16/2008 □ Other (Specify) Baltimore, Maryland 4 Donation Signature 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 11. Enter the sease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final metastalu **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of) if any leading to immedit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-transit Due to (or as a consequence of) 68760, SS attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. After this certificate has been signed by the funeral director, page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred ospital or Attending I hours after death. 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) £790600CT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Weeken Blud lakville mod 234 Karen K. Gira mi 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 1 5 2008 Registrar

DHMH 17 Rev 1/2001

CO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7:32 a February Louis Melerba Jolicoeur 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3511 Sharonwood Road, Apt. 1B Anne Arundel Laurel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct | 1974 | 1929 Social Security Number 6 Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Country) Haiti 1⊠M 2□F 78 113-42-1264 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Anne Arundel Laurel 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Haiti 20724 3511 Sharonwood Road, Apt. 1B 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 4. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Toll Operator Airport 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maxance Jolicoeur Constance Desnoyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14023 Castle Blvd., Apt. 403, Silver Spring, MD20904 Michael Jolicoeur/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
St.Michael's Crem. Date 16, 20a. Method of Disposition 20c. Location - City or Town, State Feb. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State East Elmhurst, NY 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. · Keis Skiles 313 Talbott Ave., Laurel, MD 20707 M01053 23a. 271. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTERIOSCLEROTIC HYPERTENSIVE HEART DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se a consequence offi Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENAL DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital:

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

"natural", or Items 23a or 28a-f show idical Examiner must be notified at

other traumatic event, the Medical

1 and 2 should be filed w Health and Mental Hygie em 27 is marked other ti

f Health

permit. Pages 1
Department of H
Important: If Ite
any Injury or ot

Pages 1

within 72 hours after death

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examiner

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Completed

Be

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Medical

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

/Medical

sician and burial-transit the death certificate be executed P.O. Box 68760, signed by the a d be detached f Division or Vital Records,

attending physician for use as the buria Physician/Medical certificate To the Hospital or Attending Physician: Director: After this Certification: death. in by the within 24 hours after To the Funeral Dire completely filled

State Registrar

5 ☐ Pending investigation

6 ☐ Could not be

2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Injury at Work?

29d. Date signed (Month, Dav. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 2008

29b. Signature and title of certifier

Registrar's Signature

1 🔲 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) FEB 15 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MD

RES-000

2008

February

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** Bessie Karras 142008 EBRUARY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner ELAIR HEALTH AND MEHABILITATION CENTER BEZAIR 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year Feb. 8, 1921 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 218-10-7230 1 ☐ M **XX** F 87 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits ortant; If Item 27 Is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event; <u>the Medical Examiner must be notified at</u> MD Harford Bel Air Director 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 K. Burkwood Court 21015 USA Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2010 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married HIR Par R Baltimore, Maryland 21215-0036 1 ☐ Yes ♣ No Specify: ò Specify: white 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Waitress 12 permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important: If Item 27 Is marked other I any Injury or other traumatic event, <u>th</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nick Stamouli Rahenges Kaliopi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Karras-son 809 Turtlecreek Court-Bel Air, Maryland 21014 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oaklawn Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Feb. 18,2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel
And Cremation Services Newport Drive ME Forest Hill,MD 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner evero Sequentially list conditions, if any, is a list in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine and burlal-transit be execu Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical as the l ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 2x No 3 Probably 4 Unknown 1 ☐ Yes funeral director, page 2 should Completed reen COPD 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate 2XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury Within 24 hours after occur.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide after Hospital 29a. Certifier 🎏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D565 2/14/08 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAYS ST #102, BEL AIR, MD 21014

State

KHOSLA

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** TAZEL 2008 'NO A KNIGHT 07 02 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Manor Baltimore If Under 1 Year | If Under 24 Birthplace (State or Foreign Country)
 A Sex Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Days 1 M 2 P Yrs. **Director** Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show 10b. County d other than "natural", or Items 23a or 28a-f shovevent, the Medical Examiner must be notified at 1 Yes 2 No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A a1a13 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ NO Specify: Specify: Black 3 ₩idowed 4 Divorced δ Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hyglen. Important: If Item 27 is marked other that any injury or other traumatic event, the 18 once. Domostic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Wesley Blackwell Adelia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) San honoct Frank E. Blackwell - Faye Hville GA 30214

20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State on Forest 2/15/08 Baltimore MD
22. Name and Address of Facility Vaughn C. Greene Fureral Services 15/08 Gartison Forest 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York And Ballimore, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPERTENSIVE CARDOVASCULAR DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if arry, leading to initinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examine that the deeth certificate be executed and Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 2 → No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2[] No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059107 M.D 08 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS CENTER DRIVE REISTERSTOWN Mo 21136 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:42 P Catherine Philomena Lewis February 11, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 3808 Willoughby Beach Rd. Edgewood 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F Director Aug. 20, 1930 <u>216-36-2094</u> England Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits show perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Dep. (Iment of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes ¾ No Director Maryland Harford Edgewood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3808 Willoughby Beach Rd. 21040 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 XNo 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. <u>م</u> 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry altimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Albert (nmn) Jones Mary (unk) Harvey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willis D. Lewis / Husband 3808 Willoughby Beach Rd., Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nicholson Chapel Cem 2-16-08 Morgantown, WV 21. Signature Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Rd., Abingdon, MD 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 'ancreas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed burial-transi Due to (or as a consequence of): Box 68760 physician Physician/Medical the as for use a IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ۾ cate has been signated by page 2 should by 1 ☐ Yes 2 → 3 Probably 4 Unknown Completed they 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy
performed? furieral director, 25. Was case re erred medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 X No 1 ☐ Yes this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Ater Certification: Hospital or Attending 1 Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours at er death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier x certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number

State

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Edgewood, MD 21040

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Régistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 2008 **Physician** 8:42 A.M Veronica Lester February /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Sultimore
Under 1 Year If Under 24 Hrs. ·Manes Health N/A 5. Social Security Number I Under 1 Year Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M & F Maryland April 21,1933 Director 212-30-9561 74 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be norittled at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 □No Director MD Baltimore Lansdowne 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 125 Clyde Avenue 21227 United States by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Baltimore, Maryland 21215-0036 Specify: 3 XWidowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Viola Mogowski Edward Doniecki 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Koch - Daughter 7987 Scott's Maner Court Glen Burnie, MD 21061 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition West'y, Arundel 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 2-9-2008 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) Crematory
22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral rvice Licensee la 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Arterioscleratic Vascular Unknown Due to (or as a neequence of). /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duá to (or se a consequence of) Examiner The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): s been signed by the attending physician should be detached for المحددة المحد Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Ûnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe this certificate 1∐ Yes 2 **□**No or Attending Physician: 25. Was case referred to medical examiner? filled in by the funeral director, Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 1 🔲 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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**FEB 15** 

sann 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nes

Registrar's Signature

900 Caton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year February illian Lewandowski 6:05 2008 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Medical Center Johns Hopkins Itimore Year If Under 24 Hrs.
Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 😾 F Director 216-10-6122 Usual Residence of Decedent 90 Sept13.1917 Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Md. Baltimore Eastwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224-1902 7246 Conley Street U.S.A. Funeral within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: ģ White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. Im 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Food Service Baltimore City 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Stoda ည Mary Schrader traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Glen Lemantowski (son) 7246 Conley St. Baltimore, Maryland 21224 permit. Pages 1 a
Department of Hee
Important: If Item
any Injury or othe 20a. Method of Disposition
Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St.Stanislaus Cem 2-14-2008Baltimore, Maryland 22. Name and Address of Facili Kaczorowski Funeral Home, P.A 21. Signature of Funeral Service 1201 Dundalk Ave. Baltimore, Md. Part I. Enter the dise shock, or heart failure complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respirator

Due to (or as a consequence Physician hour /Medical Examiner I week rneumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ng physician and as the burial-transit certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the al 9□Unknown 9 ☐ Unknown signed by d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Nonknown cate has been signated by page 2 should by 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No 1 ☐ Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ၉ 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of Injury 28b. Time of 27. Manner of Death 1 Natural Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

utler,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

DHMH 17 Rev 1/2001

4940 Eastern Avenue,

32. Registrar's Signature

29c. License number

Baltimore, MD

29d. Date signed (Month, Day, Year)

10.

2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death L Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician**  $A^M$ Consuelo 6:15 Muniz February 14,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Stella Maris Hospice Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 □ F Director 076-52-1283 83 July 29,1924 Ponce, Puerto Rico Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f show must be notified at 10d. Inside City Limits Directo Maryland Baltimore Dundalk 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1615 Inverness Avenue Apt F 21222 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 X Yes 2 □ No Specify: Puerto Rican Specify: Hispanic 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Miquel Muniz Ramona Serrano 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 I 687 Old Post Road, Edison, New Jersey Salvador Ayala Son permit. Pages 1 and Department of Healt Important: If Item 2: any Injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart of Jesus Cem 18, 2008 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundlak, MD. 21222 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** HODGKINS LYMPHOMA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of) physician the burial Physician/Medical attending pl IF FEMALE: If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 5 ☐ Other (specify) Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 1□ Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ဥ 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA Division or HOSPICE 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 TYes 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours aft To the Funeral D Completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 15 Registrar Mark J

FEBRUARY

MUNI;

CONSUELO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death If Under 1 Year If Under 24 Hrs. Home BALTIMORE 6. Sex 1 M 2 ☐ F 5. Social Security Number **Funeral**  Birthplace (State or Foreign Country) 18-Days Hours 725 Director 3 rennsylvania 21 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f ehov other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 ☐ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21015 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 1.No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced wnite "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 ucator 5+ nameer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental McKean 70 harles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Fountain item 27 MD 21015 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 2/15/08. 4 Donation 5 Other (Specify) Evans Fuperal Chapel-Belfir 21. Signature of Funeral Service 22. Name and Address of Eachity RD RD. BALTIMORE, MD 21234 Evans Funeral Chapel-Cremation Services-Parkville Bayjolin 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Bod Disceth en disease or condition resulting in death) 509-1 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rmed? 220 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA hours after death.

Ineral Director: After this
y filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number Attending mo 037016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Cherles St, Sark 1 6701 Kehrenm. (veese, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2008 PARES Registrar

State Registrar

DHMH 17 Rev 1/2001

30. Name and address

31. Date filed (Mooth, Day,

who completed cause of death (Item 23a) (Type, Print)

|                |  | _                 | For<br>State<br>Registrar   | State of M   | aryland                                | / Depa                     | artment<br>tificate   | of H                    | ealth a                    | ind M       | ental Hy                                 | giene                    | 2008                          | 0442  |         |
|----------------|--|-------------------|---|--|--|----------------------------|---|-------------------------|----------------------------|-------------|--|--------------------------|-------------------------------|---|---------|
|                | Physicia   |                   | 1. Decedent's Name (First, Middle ERNA  |  | CE                                     |                            |   |                         |                            |             | 2. Date of Dea                           |                          | 2008 <sup>ear</sup>           | 3. Time of Death 7:10 A.                                      |         |
|                | /Medic<br>Examin   |                   | 4a. Facility Name (If not institution   | MOR  | FL                                     |                            | 4b. City. T   | own, or                 | Location of                | f Death     | i Cui ua                                 |                          | ounty of Dea                  |   | *1      |
|                | Examin   | er                | Franklin Woods Nur  | -  |  |                            |   |                         | edale                      |             |  |                          | Baltimo                       |   |         |
|                | Funeral<br>Director  |                   | 5. Social Security Number 212-30-5644   | 6. Sex<br>1 ☐ M 2 ☐ F  | e (In yrs. lasi<br>75                  | t birthday)<br>Yrs.        | If Under 1<br>Months  | Days                    | If Under a                 | Min.        | 8. Date of Birt<br>(Month, Da<br>January | 24, 19                   | 9. Bir<br>Ca<br>Mar           | thplace (State or Foreig<br>ountry)<br>yland                  | חק      |
|                | /land  |                   | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, T                           | Town or Lo                 | cation  |                         |                            |             |  |                          |                               | 10d. Inside City Limit  | s       |
|                | e Man<br>a-fsh<br>illi   | ctor              | Maryland Ba   | ltimore  | Pa                                     | rkvill                     | .e  |                         |                            |             |  |                          |                               | 1 Tyes 2 N  | 0       |
|                | be filed within 72 hours after death with the Maryland Hygiene. d other than "naturel" or items 23e or 28e-f show event, it a Modical Ever in art must be rediffed as                              | Funeral Director  | 10e. Street and Number  |  |  |                            | 10f. Zip (  |                         |                            |             | -  | 10g. Citize              | on of What Co                 | ountry?   |         |
|                | ns 23c   | eral              | 3513 Woodring Avenu   | 12. Was Decedent   | Ever in U.S.                           | 13. \                      |   |                         | spanic Orio                | gin? (Spe   | cify Yes or No                           |                          | 1. Race - Ame                 | encan Indian,   |         |
| ဖွ             | or Iter  | Fun               | 1 ☐ Never Married 2 ☐ Marr  | Armed Forces?<br>ied 1 ☐ Yes 2 🔀<br>If Yes, Give                       |  |                            | fYes, speci<br>1 ☐ Yes 2  |                         | n, Mexican<br>Specify:     | , Puerto F  | cify Yes or No<br>Rican, etc.)           |                          | Black, Whi<br>Specify: Wh     |   |         |
| 93             | urel'.   | d by              | 3 Widowed 4 Divorced  | Year or Dates:   |  |                            |   |                         |                            |             |  |                          |                               |   |         |
| 7              | in 72<br>n "nat  | plete             | 15. Deceden<br>(Specify only higher   | st grade completed)  |  | (Give<br>life. l           | dent's Usual<br>kind of work<br>DO NOT use  | k done d<br>e retired,  | ation<br>furing most<br>)  | t of workin | ng                                       |                          | d of Business                 | Industry  |         |
| 212            | filed within<br>Hygiene.<br>Ither than "<br>ent, II.A. Me.   | Completed         | Elementary/Secondary (0-12)   | College (1-4or   | 0+)                                    | Home                       | maker   |                         |                            |             |  | Own H                    | lome<br>————                  |   |         |
| Ĕ              |  | To Be (           | 17. Father's Name (First, Middle, Edward Garrett  | Last)  |  |                            |   |                         | 18. Mothe<br>Marie         | e Holm      | (First, Middle,<br>sted                  | Maiden S                 | umame)                        |   | _       |
| , Mar          | nd 2 sh<br>lith and<br>27 is m<br>r treum  |                   | 19a. Informant's Name/Relations Donald Morfe/Husba  |  |  | 3513                       | 3 Woodri  | ing A                   | lvenue                     |             | ville <b>M</b> a                         | -                        |                               |   |         |
| Baltimore,     |  |                   | 20a. Method of Disposition  1 Burial 2 Cremation  | 3 □Removal from State  | 20b. Plac                              | e of Dispo<br>letery, cren | sition (Name<br>natory or oth   | e of<br>her place       | θ)                         | D           | ate                                      | 20c. Loca                | ation - City or               | Town, State   |         |
| tim            | t. Partment  |                   | *4 □Donation *5 □ Other (S  | pecify)  | Hil                                    |                            | ervice  |                         |                            | 2/18        |  |                          | Maryla                        | nd  |         |
| Bal            | Deparing Deparent Important in any ire gonce.  |                   | 21. Signature of Funeral Service  | delton   |  | Le<br>53                   | onard on the control of the control | J. Ri<br>ford           | ick Ind<br>Road            | y<br>Balti  | more Mar                                 | yland                    | 21214                         |   |         |
|                | Medical<br>Examiner  | Iner              | 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | aDue to (or as   | a consequer                            | TA                         |   |                         |                            |             | ANO                                      |                          | -                             | Approximate<br>Interval Between<br>Onset and Death            |         |
| x 68760,       | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit                                 | /Medical Examiner | Cause (Disease or injury that initiated events resulting in death) Last   | d  | a consequer                            |                            |   |                         |                            |             |  |                          | Pala of de                    | lives   |         |
| О. Вох         | at the death of the by the attendached for u   | Physician/Med     | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  | 1 ☐ Live birth<br>4 ☐ Pregnant a<br>9 ☐ Unknown                        | 2 Fetal de                             | eath 3                     | Ectopic pre Other (spe  |                         |                            |             |  | 23                       | 3d. Date of de<br>Month       | Day Year  |         |
| rds, P         | quires that<br>en signed b   | by                | Part II. Other significant conditi  | ons contributing to death t  |  |                            |   | iuse give               | en in Part I               |             | 23e. Did t                               |                          | ,                             | o the cause of death?<br>robably 4 Unknow                     | ۷N      |
| Vital Records, | en: The law requitificate has been tor, page 2 should  | Completed         |   |  |  |                            |   |                         |                            |             | 24a. Was<br>auto<br>perfo<br>1 Tyes      |                          | 24b. Were a prior to death?   | utopsy findings availab<br>completion of cause of<br>s 204 No | le<br>f |
| Vita           | yslcien: Th<br>is certificate<br>director, pag   | Be                | 25. Was case referred to medica examiner?   | Hospital:  |  |                            |   | A Othe                  |                            |             | (Check only o                            |                          |                               |   |         |
| of             | g Phys<br>ter this<br>neral di   | 7: To             | 1 ☐ Yes SQ No<br>27. Manger of Death  | 28a. Date of Inj<br>(Month, Date                                       |  | 8b. Time o                 | nt 3 D0/  | A<br>Bc. Injury<br>Work | 41,8640                    |             | ne 5 ☐ Resi<br>28d. Describe             |                          |                               | ecify)  | _       |
| ion            | utending R<br>death.<br>ctor: After<br>/ the funer   | atio              | 1 ☑ Natural 5 ☐ Pendir<br>2 ☐ Accident investi  | gation   | ly Year)                               | Injury                     | М   |                         | <br Yes 2□                 | No          |  |                          |                               |   |         |
| Division       | el or Attences after death   | Certification:    | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide determ  | 289. Place of III  | jury - At hom-<br>tc. <i>(Specily)</i> | e, farm, str               | reet, factory,  | , office                |                            | 2           | 28f. Location (<br>City or To            |                          | Number or F                   | lural Route Number,   |         |
|                | To the Hospitel or Attending Physicien: within 24 hours after death To the Funeral Director. Alter this certification place to the funeral director, completely filled in by the funeral director, | Medical C         | 29a. Certifier A Certifyin (Check only one)   | ng Physicien: To the best<br>Examiner: On the basis of<br>and manner s | of examination                         | edge, deat<br>n and/or in  | h occurred a vestigation,   | at the tim<br>in my of  | ne, date an<br>pinion, dea | d place, a  | and due to the<br>ed at the time,        | cause(s) a<br>date and p | and manner a<br>place, and du | s stated.<br>e to the cause(s)                                |         |
|                | To the Comp  | M                 | 29b. Signature and title of certifie  | 0 /  |  |                            |   |                         | e number                   |             |  |                          |                               | th, Day, Year)  |         |
|                | ,  |                   | yem   | taishall   |  |                            |   | D4                      | 100                        | 08          |  | 71                       | 14/0                          | 8   |         |
| 2              | <u></u>  |                   | 30. Name and address of person  | who completed cause of   | death (Item 2                          | 3a) (Type,                 | Print)  | S                       | (0., 6)                    | 126         | DR                                       | BA,                      | TIHA                          | PE, MD  | )       |
|                | Sta  | ate               | 31. Date filed (Month, Day, Year,   | 32. <b>Re</b> gist   | rar's Signatur                         |                            | 4-  |                         | COM                        |             |  | DIL                      | - ( () (0                     | , - , - , - , - , - , - , - , - , - , -                       | 1       |
| L              | Regist   |                   | EFR 1   | 2008   | w B                                    | 1                          | and!  |                         |                            |             |  |                          |                               |   |         |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month MILLER Year Physician 16:26 LLLIAN FEBRUARY 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltiomore City THE JOHNS HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign
 Country) **Funeral** 1 □ M 2 1 F Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or not any injury or other traumatic event. The Medical is not items 200 or not one. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 **∏re**s 2 □ No **Funeral Director** HMORE 10g. Citizen of What Country? 100dlea Ac Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) ears OCIAL 18. Mother's Name (First, Middle, Maiden Surnam 17. Father's Name (First, Middle, Last) To Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bal D.MD 21206 Method of Disposition NZ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician amonths disease or condition resulting in death) Pancreatic cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi that initiated events and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy been signed by the atter should be detached for u Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate has performe 1∐ Yes 2 🔀 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) From Howers, MEDICAL DOCTOR RES-000 FEBRUARY 4, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FIONA P. HAUERS, JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2008

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|                |  |                | 1 - For State Registrar   | ite of Maryland / Departs of Maryland / Depa | artment of He<br>rtificate of De   | aith and Ment<br>e <i>ath</i>                                | al Hygiene<br>Reg. No                                | / 111110   | 04423  |
|----------------|--|----------------|---|--|--|--|--|--|--|
| ag.            | Physicia<br>/Medic   |                | 1 Decedent's Name (First Middle Last)   | CCUBBIN  |  |  | ate of Death   | ZOO 8  | 3. Time of Death 5:03AM                            |
|                | Examin   |                | 4a. Facility Name (If not institution, give street HARBOR HOSP  | ITAL   | 0  | IMORE  |  | c. County of Death                                 |  |
| ža.            | Funeral<br>Director  |                | 5. Social Security Number 212–46–5589 6. Sex 12 M 2   | 7. Age (In yrs. last birthday) □ F   | If Under 1 Year II Months Days   | f Under 24 Hrs. 8. Da<br>Hours Min. 4.                       | ate of Birth<br>Jonth, Day, Year,<br>ED. 5,          | 1946 9. Birthpi<br>Coun                            | lace (State or Foreign<br>try) Mary Land           |
|                | Maryland<br>t-f show<br>filed at   | tor            | Maryland 10b. County Anne Aruno   | del   10c. City, Town or Le  |  |  |  | 1  | 0d. Inside City Limits 1 ☐ Yes 2 No                |
|                | th with the<br>23a or 28a<br>ist be noti   | al Director    | 10e. Street and Number 5301 Fourth Street   |  | 10f. Zin Code<br>21225   |  | 10g Ci<br>US   | itizen of What Coun<br>A                           | try?   |
| 036            | be filed within 72 hours after death with the Maryland ttal Hygiene.  d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at   | by Funeral     | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | TVes 22 No   | Was Decedent of Hisp<br>If Yes, specify Cuban,<br>1 ☐ Yes 2 🌠 No               | anic Origin? (Specify Y<br>Mexican, Puerto Rican<br>Specify: | res or No-<br>l, etc.)                               | 14. Race - America<br>Black, White, of<br>Specify: |  |
| 1215-0036      | thin 72 hoe.<br>e.<br>an "natu<br>Medical  | Completed      | 15. Decedent's Education (Specify only highest grade complete stary/Secondary (0-12)  | oleted) (Give  | edent's Usual Occupation<br>to kind of work done during<br>DO NOT use retired) | on<br>ing most of working                                    |  | aint Comp  |  |
|                | oe filed wi<br>al Hygien<br>I other th   | Be Con         | 17. Father's Name (First, Middle, Last)  James McCubbin   | Pain   | -  | 8. Mother's Name <i>(Firs</i><br>E <b>11a</b> B <b>ri</b> r  | t, Middle, Maidei                                    |  | Daily  |
| Maryland 2     | 2 should<br>and Mer<br>is marke<br>aumatic   | To             | 19a Informant's Name/Relationship (Type, Pr<br>Sandy McCubbin, Wife   | int) 19h Maili   | ng Address <i>(Street and</i><br>1 Fourth St                                   |  |  | orTown, State, Zip                                 | 21225  |
|                | ges 1 and<br>t of Health<br>If Item 27<br>or other to  |                | 20a. Method of Disposition 11 Burial 2 □ Cremation 3 □ Remove   |  | osition (Name of ematory or other place) ark Cemete                            |  | 20c. L   | ocation - City or To                               | own, State   |
| Baltimore,     | permit. Pag<br>Department<br>Important:<br>any Injury once.  |                | 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licenses   | 2  | Androse su   | deral Home,  | Inc.   |  |  |
|                |  |                | 23a. Fart1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final                  |  | 1328 Sulphu<br>ter the mode of dying,  |  |  | utus, MD.  | 21227 Approximate Interval Between Onset and Death |
|                | Physician<br>/Medical<br>Examiner  |                | disease or condition resulting in death)  | Due to (or as a consequence of):   | al Fai   | Cili   | re Ef  | 30/  | years-   |
|                | uted   | Examiner       | Se uentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a consequence of):   | near   | Tanv   | C  |  | recent   |
| 68760,         | icate be executed<br>physician and<br>s the burial-transit   | edical Exa     | resulting in death) Last  | Due to (or as a consequence of);   |  |  |  |  |  |
| O. Box 68      | death certif<br>e attending<br>id for use as   | Physician/Medi | in the past 12 months?  |  | □Ectopic pregnancy □ Other (specify)   |  |  | 23d. Date of delive<br>Month                       | ery<br>Day Year                                    |
| ds, P          | w requires that the d<br>been signed by the<br>should be detached  | by             | Part II. Other significant conditions contribut   | ng to death but not resulting in the   |  | in Part I.   |  | use contribute to th                               | ne cause of death?                                 |
| Vital Records, | The lar  | Completed      |   |  |  |  | 24a. Was an<br>autopsy<br>performed?<br>I□ Yes 2 2 N | death?   | psy findings available mpletion of cause of        |
| VITA           | slcian:<br>certifica<br>rector, l  | Be             | 25. Was case referred to medical examiner?  1 Yes 2 No Hospita  | al:  | Other  | 26. Place of Death (Che                                      |  |  |  |
| ion or         | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,   | ation: To      |   | a. Date of Injury (Month, Day Year)  2 □ ER/Outpatie 28b. Time of Injury   | of 28c. Injury a Work?   | 4 ☐ Nursing Home  at 28d. [ as 2 ☐ No                        | 5 ∐ Residence<br>Describe how inji                   | - ' ' '  | ý)<br>   |
| DIVISION       | al or Atte<br>s after des<br>al Directo  | Certification: | 3 ☐ Sulcide 6 ☐ Could not be determined 286   | e. Place of injury - At home, farm, st<br>building, etc. (Specify)   | treet, factory, office   | 28f. L   | ocation (Street a<br>Dity or Town, Sta               | and Number or Rura<br>te)                          | al Route Number,                                   |
|                | ne Hospit<br>n 24 hour<br>ne Funera  | edical (       | (Check only 2 Medical Examiner: C   | To the best of my knowledge, dea<br>on the basis of examination and/or ind<br>and manner stated.   |  |  |  |  |  |
| )              | To the Configuration of the Co | Me             | 29b. Signature and title of certifier   | ATK DEUMINI, I   | 29c. License n   | lumber<br>000  | 29d. D   | ate signed (Month,                                 | Day, Year)   |
|                | 5  |                | 30. Name and address of person who complet  | ER/STE BALT  | Print) BAB   | MARY   | IAND   | M) .   |  |
| \$             | Sta<br>Registi   |                | 31. Date filed (Month, Day, Year)<br>FEB 1 5 2008   | 32. Registrar's Signature  |  |  |  |  |  |

DHMH 17 Rev 1/2001

State

DHMH 17 Rev 1/2001

**OCME 2006** 

Registrar

OCME

30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32.

egistrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

February 13, 2008

| 08-01054   |                | Please Type or Print in Black Indelible Ink. En  |  | ible.   |
|--|----------------|--|--|---|
| Herbert Newborn,   |                | State of Maryland / Department of Health 1-For State Certificate of Death  | , ,  | 2008 04425                                    |
| Physicial  |                | Registrar  | Reg<br>2. Date of Death  | J. No.  |
| Medical Examin   |                | Herbert Newborn Jr.  | Month<br>February 6  | Day Year 0802 hrs                             |
| 3  |                | 4a. Facility Name (if not institution, give street and number)  4b. City, To   | wn, or Location of Death   | 4c. County of Death                           |
| _  | 4              | 5220 York Road, Apt. 9A  Baltime   |  | (MM/DD/YYYY) 9. Birthplace (State or Foreign  |
| Funeral<br>Director  |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months  | Dave Hours Min   | Country)                                      |
|  | 4              | 217 · 66 · 7378   14 M 2 F   50 Yrs.   | Days 110013 11111. 1.16.   | 1958   7/115                                  |
| , any  |                | 10a. State 10b. County 10c. City, Town or Location   |  | 10d. Inside City Limits                       |
| land<br>f show   | ٦              | MD Baltimore   |  | 1 Ves 2 No                                    |
| Mary r 28a-  | 90             | 10f. Zip 0   |  | g. Citizen of What Country?                   |
| 11576<br>reach with the Maryland<br>or items 23a or 28a-f show<br>must be notified at once.  |                | Saao York Ind Apt 9A   a\tag{11. Marital Status}   12. Was Decedent Ever in U.S.   13. Was Decedent  | t of Hispanic Origin? ( Specify Yes or No-                       | 14. Race - American Indian, Black,            |
| eath w   | Funeral        | 1 Never Married 2 Married Armed Forces? If Yes, specify  | Cuban, Mexican, Puerto Rican, etc.)                              | White, etc.                                   |
| after d  | by<br>F        |  | No specify:  | specify: BIGCK                                |
| hours<br>natura  | 힣              | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual O   | occupation (Give kind of work done ing life. DO NOT use retired) | 16b. Kind of Business/Industry                |
| 36<br>in 72<br>han "   | Bet            | Elementary/Secondary (0-12)  College (1-4 or 5+)   | Sharon   | 11010-0-01                                    |
| 5-0036<br>led within 7<br>Hygiene.<br>other than   | Completed      | 17. Father's Name (First, Middle, Last)  | 18.Mother's Name (First, Middle, M                               | laiden Surname)                               |
| 21215<br>buld be file<br>Mental H<br>marked o  | Be             | Herbert Newborn St.  | Ponnie P   | Branch  |
| 22 Med Me  |                |  | (Street and Number or Rural Route Num                            |   |
| MD and 2 sho salth and 2 sho sem 27 is   |                | 20a. Method of Disposition (Name 20b. Place of Disposition (Na | e of cemetery. Date  | 20c/Location - City or Town, State            |
| altimore<br>mit. Pages I a<br>partment of He<br>portant: If its  |                | 1 Burial 2 Cremation 3 Removal from State crematory or other place)  |  |   |
| it. Pa   | ŀ              | 4 Donation 5 Other Specify: Cedar Hill 21. Signature of Funeral Service Licensee 22. Name and A  | Address of Facility VI 0   |   |
| Balti<br>permit.<br>Departn<br>Imports<br>Injury o   |                | Vaughn C. Sheare 4905 40   | ock and Baltimore  | Greene Funeral Services MD 21212              |
| Physician  |                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of failure. List only one cause on each line.  | dying, such as cardiac or respiratory a re                       |   |
| /Medical<br>vaminer  |                | Immediate Cause (Final disease a. Methadone intoxication   |  | Death   |
|  |                | or condition resulting in death)  Due to (or as a consequence of):   |  |   |
|  | ē              | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  |  |   |
|  | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death. Last Due to (or as a consequence of):   |  |   |
| vecuted n and - transit  |                | events resulting in death) East  |  |   |
| oe exec  | dical          | X UNPENDED AMENDED 27.28a-f. TOTME v877.3/11   | /08 TT   |   |
| Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.  The funeral Director: After this certificate has been signed by the attending physician and impletely filled in by the funeral director, page 2 should be detached for use as the burial - transit |                | 23c. If yes, outcome of pregnancy  |  | 23d. Date of delivery                         |
| c 68<br>r certif<br>ending<br>use as   | lä.            | past 12 months?  | 3 Ectopic pregnancy  | Month Day Year                                |
| Box<br>e death c<br>the atten  | Physicia       | 1 Yes 2 No 9 Unknown g Unknown   |  | 9   |
| b.O. that the the detach   | by P           | Part II. Other significant conditions contributing to death but not resulting in the underlying  |  | bacco use contribute to the cause of death?   |
| IS, P  |                |  | 1 Yes  |   |
| of Vital Records, ig Physician: The law requir fuler this certificate has been is neral director, page 2 should be   | Completed      |  | autop:   | sy prior to completion of cause of            |
| tal Rec  | 등              |  | 1 Yes  |   |
| Vital<br>ysician:<br>his certi   | å              | examiner? Hospital:   Inpution 2 FR/Outpution 3 PM   | 16.Place of Death (Check only one)  OA Other Nursing Home 5      | Residence 6 V Other: Scene                    |
| n of Vi<br>ding Physi<br>After this<br>funeral dir   | <u>اء</u>      | 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 2  |  | now injury occurred                           |
| Sion of trending death.  | 힐              | 1 Natural 5 Pending Fnd 2/6/2008 Fnd 7:55 am   | 1 Yes 2 X No unk   |   |
| Division fal or Attendi rs after death. al Director: A   | <u> </u>       | 2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory,   | office building, etc. 28f. Location (S or Town, S                | Street and Number or Rural Route Number, City |
| Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the  | Certification: | 4 Homicide determined (Specify) House  | 5220 York  | Rd. Apt 9A Baltimore, MD                      |
| To the Hos<br>within 24 h<br>To the Fun<br>completely  |                | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the cone) 2 Medical Examiner: On the basis of examination and/or investigation, in my  |  |   |
| To (1) Within Comp   | Medical        | and manner stated.   | License number   | 29d. Date signed (Month, Day, Year)           |
|  | 7.7            | Out D.   | O.C.M.E.   | February 7, 2008                              |
| 61   |                | 30. Name and address of person who completed cause of death (Item 23a)   |  |   |
| 20 pend  |                |  | altimore, MD 21201   | (N  |
| Sta  |                | 31. Date filed (Month, Day, Year)  32. Registrar's Signature   |  |   |
| Regist   | खा             | FEB 1 5 2008 France 18 19 19 19 19 19 19 19 19 19 19 19 19 19  |  |   |

|                            |   |                  | 1 - For<br>State<br>Registrar   | State of I   | Marylar                 | nd / Depa                          | artmer                      | t of H                   | ealth a                           |            | lental Hyg                                | jiene<br>leg. No.     | 200                           | 8 01                               | 1426                    |
|----------------------------|---|------------------|---|--|-------------------------|------------------------------------|-----------------------------|--------------------------|-----------------------------------|------------|---|-----------------------|-------------------------------|------------------------------------|-------------------------|
|                            | Physici   | an               | Decedent's Name (First, Middle, Las   | •  |                         |                                    |                             |                          |                                   |            | 2. Date of Dea<br>Month                   | Day                   | Year                          |                                    | of Death                |
|                            | /Medic  |                  | Angelina D. Palas   |  |                         |                                    |                             |                          |                                   |            | 02-09-2                                   | T                     |                               | 505                                | р м                     |
|                            | Examin  | er               | 4a. Facility Name (If not institution, give<br>1600 Shield Road                 | street and numb  | er)                     |                                    |                             | Town, or<br>1sto         | Location o                        | of Death   |   |                       | County of De<br>larford       |                                    |                         |
|                            | Eugenel   |                  | 5. Social Security Number 6. Se   | x 7.   | Age (In vrs.            | last birthday)                     | If Unde                     |                          | If Under:                         | 24 Hrs.    | 8. Date of Birth                          |                       |                               | -                                  | e or Foreian            |
|                            | Funeral Director  |                  |   | ⊐м 2 <b>Ж</b> ] F                                      | 89                      | Yrs.                               | Months                      | Days                     | Hours                             | Min.       | 8. Date of Birth<br>(Month, Day<br>01-19- | , Year)<br>1919       |                               | rthplace (State<br>Sountry)        |                         |
|                            | p _   |                  | Usual Residence of Decedent   |  |                         |                                    |                             |                          |                                   |            |   |                       |                               |                                    |                         |
|                            | ehow  | -                | 10a. State 10b. County  |  | 10c. Ci                 | ty, Town or Lo                     |                             |                          |                                   |            |   |                       |                               | 10d. Inside                        | City Limits<br>es 2X No |
|                            | 28a-1   | ecto             | Maryland Harford  |  |                         | Fa.                                | llsto                       |                          |                                   |            |   | ton Citin             | en of What C                  |                                    |                         |
|                            | with with   | Funeral Director |   |  |                         |                                    | 10f. Zip                    |                          |                                   |            |   | rog. Oniz             |                               | ,                                  |                         |
|                            | ne 23   | era              | 1600 Shield Road  | 12. Was Decede   | nl Ever in U            | I.S. 13. V                         | Nas Dece                    | 210<br>dent of Hi        |                                   | gin? (Spe  | ecify Yes or No-<br>Rican, etc.)          | 1                     |                               | erican Indian,                     |                         |
| 9                          | or Ite  | Ē                | 1 Never Married 2 Married   | Armed Force  |                         |                                    |                             |                          |                                   | i, Puerto  | Rican, etc.)                              |                       | Black, Wh                     | ite, etc.                          |                         |
| င္က                        | rel', c   | d by             | 3 XWidowed 4 ☐ Divorced   | If Yes, Give<br>Year or Date                           | s:                      |                                    | 1 🗌 Yes                     | 2 <u>M</u> No            | Specify:                          |            |   |                       | Specify: W                    | Thite                              |                         |
| 21215-0036                 | within 72 hours after deeth with the Maryland<br>ene.<br>then "neturel", or lteme 23e or 28e-f ehow<br>he Madigal Examination man be mailled at   | Completed        | 15. Decedent's Ed<br>(Specify only highest grad                                 | ucation<br>de <i>completed)</i>                        |                         | 16a. Deced<br>(Give                | tent's Usu<br>kind of wo    | al Occupa<br>nk done d   | ation<br><i>luri</i> ng most<br>) | t of worki | ng  | 16b. Kin              | d of Busines                  | s/Industry                         |                         |
| 12                         | withir<br>and<br>then<br>be M   | d mc             | Elementary/Secondary (0-12)   | College (1-4   | or 5+)                  |                                    | ory                         |                          |                                   |            |   | ηı                    | extile                        |                                    |                         |
| 0                          | Hygi<br>Hygi<br>other   | Be Co            | 17. Father's Name (First, Middle, Last)   |  |                         | ract                               | .OLy                        | WOIR                     |                                   | r's Name   | (First, Middle,                           |                       |                               |                                    |                         |
| au                         | lid be<br>fental<br>rked<br>ric ev  | To B             | Antonio DiBartolo   | meo  |                         |                                    |                             |                          | Gene                              | viev       | e Frate                                   | tta                   |                               |                                    |                         |
| Maryland                   | and A   |                  | 19a. Informant's Name/Relationship (7   | ype, Print)  |                         | 19b. Mailin                        | ng Address                  | (Street a                | and Numbe                         | r or Rura  | il Route Numbe                            | r, City or            | Town, State,                  | Zip Code)                          |                         |
| Σ                          | and 2<br>ealth<br>n 27 i  |                  | Geneine Shaw (Da  | ughter)  |                         |                                    |                             |                          | Rd Fa                             |            | on, MD_                                   | 2104                  | 7                             |                                    |                         |
| Baltimore,                 | ges 1<br>t of H<br>if ite   |                  | 20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐                       | Removal from Sta                                       |                         | Place of Dispo<br>cemetery, cren   | sition (Name<br>natory or c | ne of<br>ther place      | e)                                | C          | Date                                      | 20c. Loc              | ation - City o                | r Town, State                      |                         |
| Ē                          | t. Pertant:   | . )              | 4 ☐ Donation 5 ☐ Other (Specify   |  | Mos                     | t Holy                             | Rede                        | emer                     | 0                                 |            | -2008                                     |                       |                               |                                    |                         |
| Ba                         | permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Metal Hygiens. Department of Health and Metal Hygiens in Theme 23a or 28a-1 show important; if item 27 is marked other than "nature", or fleme 23a or 28a-1 show eny Injury or other treumatic event, the Medical Expringer must be notified at QREs. |                  | 21. Signature of Funeral Service Licens   | Ru   | uki                     | _ Ir                               | ıc. 6                       | 10 W                     |                                   | Phai       | imunek 1<br>1 Rd Be                       | 1 Ai                  | ral Hon<br>r, MD              | ne of Be<br>21014                  | el Air                  |
|                            |   |                  | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only of | lications that cause<br>ne cause on each               | sed the deal<br>h line. | th. Do not enle                    | er the mod                  | le of dying              | g, such as                        | cardiac d  | or respiratory are                        | est,                  |                               | Approxim<br>Interval B<br>Onset an | Between                 |
|                            | Physician<br>/Medical   | 1                | Immediate Cause (Final disease or condition resulting in death)                 | a. Cur   | dron                    | matr                               | the                         |                          |                                   |            |   |                       |                               |                                    |                         |
|                            | Examiner  |                  |   | Due to (or   | as a consec             | quente of):                        | 14                          | 7                        |                                   |            |   |                       |                               |                                    |                         |
|                            | 1 13  | er               | Sequentially list conditions, if any, leading to immediate                      | b. Due to (or  | as a consec             | quence of):                        |                             |                          |                                   |            |   |                       |                               |                                    |                         |
| /                          | outed<br>ansit  | Examiner         | Cause (Disease or injury that initiated events                                  | c  |                         |                                    |                             |                          |                                   |            |   |                       |                               |                                    |                         |
| >,092                      | ate be executed<br>hysiclen and<br>he burial-transit  |                  | resulting in death) Last  | Due to (or   | as a consec             | quence of):                        |                             |                          |                                   |            |   |                       |                               |                                    |                         |
| 876                        | ate by  | lcal             |   | d  |                         |                                    |                             |                          |                                   |            |   |                       |                               |                                    |                         |
| <u>ت</u><br>×              | death certificate be executed<br>e ettending physicien and<br>od for use as the burial-transit  | Physiclan/Med    | IF FEMALE:  | 23c. If yes, outcor                                    | ne of preon             | ancy                               |                             |                          |                                   |            |   |                       |                               | P                                  | -                       |
| .О. Вох                    | etten<br>for u  | clan             | in the past 12 months?  | 1□Live birth<br>4□Pregnan                              | 2 Feta                  | al death 3                         | Ectopic p                   |                          |                                   |            |   | 2.                    | 3d. Date of d<br>Month        | Day                                | Year                    |
| o                          | the d   | hysi             | 1 Yes 2 No<br>9 Unknown   | 9☐ Unknow  |                         |                                    |                             | 7/                       |                                   |            |   |                       |                               |                                    |                         |
| ري<br>ص                    | Physicien: The law requires that the de-<br>this certificete hes been signed by the e-<br>ral director, page 2 should be detached f   | by P             | Part II. Other significant conditions co  | ntributing to deat                                     | h but not res           | sulting in the ur                  | nderlying o                 | ause give                | en in Part I.                     |            | 23e. Did to                               | bacco us              | e contribute                  | to the cause o                     | of death?               |
| Division of Vital Records, | w require<br>been sig<br>should b   |                  |   | ····-  |                         |                                    |                             |                          |                                   |            | 1 🗆 Y                                     | es 2                  | ]No 3□F                       | Probably 4                         | QUnknown                |
| ec                         | hes be<br>pe 2 sh   | Completed        |   |  |                         |                                    |                             |                          |                                   |            | 24a. Was a                                |                       | 24b. Were a                   | autopsy finding<br>completion o    | gs available            |
| <u>~</u>                   | hysician: The la<br>his certificete he:<br>I director, page 2   | Con              |   |  |                         |                                    |                             |                          |                                   |            | perfor                                    | męd?                  | death?                        | s 2000                             |                         |
| Vita                       | ician<br>certifi<br>ector   | Be               | 25. Was case referred to medical examiner?                                      | Hospital:  |                         |                                    |                             | 100                      |                                   | of Death   | Check only or                             | ne)                   |                               |                                    |                         |
| ō                          | Phys<br>raldir  | . To             | 1 Yes 2 No 27. Manner of Death  | 1 ∐ Inp  |                         | ER/Outpatien                       |                             | Othe<br>18c. Injury      | 4   140                           |            | me 5 Resid<br>28d. Describe h             |                       |                               | ecify)                             |                         |
| 0                          | Attending ir death. ector: After by the fune  | tlor             | Natural 5 Pending 2 Accident investigation                                      | 28a. Date of I<br>(Month,                              | Day Year)               | Injury                             | м                           | Work                     | (?<br>Yes 2∐1                     |            | 200. 20001100 11                          | on injury             | 55541154                      |                                    |                         |
| N S                        | r Attending Phy<br>ler death.<br>Irector: Atter this<br>by the funeral d  | Ifica            | 3 Suicide 6 Could not be determined   | 286. Place of  | Injury - At h           | ome, farm, stre                    | eel, factor                 | , office                 |                                   |            | 28f. Location (S                          |                       |                               | Rural Route N                      | umber,                  |
|                            | tal or<br>rs afte<br>al Dir<br>ed in  | Certification;   | 4 - Hottiicide  | building,  | elc. (Specia            | (Y)                                |                             |                          |                                   |            | City or Tow                               | n, State)             |                               |                                    |                         |
|                            | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the  | edical           | 29a. Certifier (Check only one) Certifying Phyone 2 Medical Example 1           | rsician: To the be<br>iner: On the basis<br>and manner | s of examina            | owledge, death<br>ation and/or inv | occurred<br>restigation     | at the tim<br>, in my op | e, date and<br>pinion, deat       | d place, a | and due to the d<br>ed at the time, d     | ause(s) a<br>late and | and manner a<br>place, and du | as stated.<br>ue to the caus       | e(s)                    |
|                            | To the To the Comp  | ž                | 29b. Signature and title of certifier   |  |                         |                                    | 290                         | . License                | number                            |            |   |                       |                               | nth, Day, Year                     |                         |
| ,                          |   |                  | Dad TI  |  | •                       |                                    |                             | 0)                       | 3 22                              | -55        |   | Fed                   | CDAL                          | 12;                                | 2008                    |
|                            | 10  |                  | 30. Name and address of person who o  |  |                         | , , , , .                          | ,                           |                          | _                                 | ,          |   |                       |                               | ,                                  |                         |
| 7                          |   | •                | 31. Date filed (Month, Day, Year)   |  | istrar's Signa          | . M / _ (                          | 1,44                        |                          | Rel                               | (A)        | rmp                                       |                       |                               |                                    |                         |
|                            | Registr   | _                | FEB 1 5 200   |  | ر ل                     | 6084                               | BI                          |                          |                                   |            |   |                       |                               |                                    |                         |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** 12:20AM Theda Mae Pagan Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Co. 4134 Rock Run Road Havre De Caulif Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 14,1923 Havre De Grace 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M **XX** Director 212-22-0906 84 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or itema 23a or 28a-f eho: other traumatic event, the Medical Examinar must be notified at Maryland Harford Co. Havre De Grace Director 1 Yes 2000 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4134 Rock Run Road 21078 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 11. Marital Status 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXVo Yes, Give Specify: Specify: White XXWidowed 4 Divorced Maryland 21215-003 Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) i Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fi of Heelth and Mental H I Item 27 is marked oth Be Julia McNut George Botts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 5 0 0 6 19a. Informant's Name/Relationship (Type, Print) 414 Spring Creek Rd. Boulder Creek, Dennis Adams (Son-In-Law) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 0 = 6 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: ff eny injury or Evans Funeral Cha. 2/9 2008 Forest Hill, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services er 3 Newport Dr. Forest Hill, 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying; such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 21910 1 Yes 2 No Division of Vital or Attending Physicien: funeral director, Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 0 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer 1- Natural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fur 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a. Certifier 29b. Signature nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 ne and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** BARBARA CECILE PROSSER-COMANDO FEBRUARY 8, 2008 5:37 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Harford Memorial Hospital Havre de Grace Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🕃 F Director 007-68-3911 2, 1966 Maine Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f shov notifled at 1 ☐ Yes 2 No Directo Maryland | Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? if item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be or 1819 Tower Road 21001 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify. Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Mental Health and Menta em 27 is marked Lawrence Elwood Prosser Edith Farrington Orrise ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Lee Skillman Sr. / Husband 1819 Tower Road, Aberdeen, Maryland 21001 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ŏ 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hilltop Service Corp. 2-14-08 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dille 14 **Physician** WH ivee /Medical .Due to (or as a consequence of) Examiner Tenlo bular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated executions) Due to (or as a consequence of). Examiner law requires that the death certificate be executed burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No ģ Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) by the a o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Record Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed? 1XYes 2 No 2 No Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) DEAT 2 No P 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA ō 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Naturai 5 Pending investigation M 1 ☐ Yes 2 ☐ No 3 2 Accident by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 1 29a. Certifier and manner stated. within 2

To the I

complet M 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) eget. 20021169 30. Name and aud Alberto Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesapeake Dive Bel Air, Md. 21014 Seigner 500 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 12:32 PM Edward 3 teb /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore VA Medical Centler 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3 / 0 7 / 1 9 5 9 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days 1 € M 2 □ F 48 MARYLAND 268-68-2485 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo BALTIMORE PARKVILLE Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? KINGSTREE RD 9211 APT 201 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No
If Yes, Give 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married Married If Yes, Give Year or Dates: 1984-87 1 ☐ Yes 2X No Specify Specify: þ WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CAR PAINTER 12 AUTOMOTIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CAROLYN SETTLE CHARLES E. PAYNE SR. ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAROLD\_PAYNE/ UNCLE 3409 ACTON ROAD BALTIMORE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐ Removal from State METRO CREMATORY 2/14/08 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Livensee 1211 CHESACO AVENUE BALTO., MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) squamous Due to (or as a consequence of): Sequentially list conditions, if any to all to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Probably 4 □Unknown 2 No 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA Inpatient 2 ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician the as use þ the

**Physician** 

/Medical

Examiner

**Physician** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

has page 2 director. this filled in by the funeral After death. 24 hours after death e Funeral Director:

Physician:

or Attending

Hospital

within 2

No Ti

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of gertifier

29a. Certifier

29c. License number

11 State

ca

Medi

31. Date filed (Month, Day, Year

M.D 32. Registrar's Signatur 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

sore mi)

and manner stated.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

|                            |   |                     | riogistiai  |                              | s 18, 29d  | per fl                        | n,dr                | ### <b>876.02</b>  | 6.615/08dhb  |                                 | neg. Ito.                     | 2008  | 04                       | 430           |  |
|----------------------------|---|---------------------|---|------------------------------|--|-------------------------------|---------------------|--|--|---------------------------------|-------------------------------|---|--------------------------|---------------|--|
|                            | Physici   | an                  | 1. Decedent's Name (F   |                              | <b>'</b>   | 7                             |                     |  |  | 2. Date of De<br>Month          | Day                           |   | 3. Time o                |               |  |
| 1,38                       | /Medio  | and the same        | 4a. Facility Name (If no  |                              | Peacock,   | sr.                           |                     | 4h City Town o   | or Location of Death                                     | Feb.                            | 11                            | 2008<br>County of Death                       | 5:12                     | A "           |  |
|                            | Examir  | er                  | Gilchrist   |                              | e street and number)   |                               |                     | _  |  |                                 | 40.                           | ,   |                          |               |  |
|                            | Funeral   |                     | 5. Social Security Num  |                              | ex 7. Ag   | e (In yrs. last               | birthday)           | Towso<br>if Under 1 Year                                   | If Under 24 Hrs.   | 8. Date of Bir                  | th                            | Baltim<br>9. Birth                            | place (State             | or Foreign    |  |
| Ļ                          | Director  | 0                   | 215-24-61<br>Usual Residence of De  |                              | □M 2□F   | 78                            | Yrs.                | Months Days  | Hours Min.   | July 3                          | y, Year)<br>0 19              | 29 MD   | intry)                   |               |  |
|                            | yland<br>now<br>at  |                     | 10a. State 10   | b. County                    |  | 10c. City, To                 | own or Lo           | ocation  |  |                                 |                               |   | 10d. inside C            | ity Limits    |  |
|                            | Mar<br>1-f sh<br>fled   | to                  | MD  | Baltimo                      | re   | Co                            | ockey               | sville   |  |                                 | 1 □ Yes 2 No                  |   |                          |               |  |
|                            | or 28   | irec                | 10e. Street and Number  | er                           |  |                               |                     | 10f. Zip Code  |  |                                 | 10g. Citiz                    | zen of What Cou                               | intry?                   |               |  |
|                            | th wil  | al                  | 10009 Pro   | ducts D                      | r.   |                               |                     | 21   | 030  |                                 |                               | USA   |                          |               |  |
| 21215-0036                 | be filed within 72 hours after death with the Maryland<br>stal Hygiene.<br>ed other than "natural", or items 23a or 28a-f show<br>event, the Medical Examiner must be notifled at | by Funeral Director | 11. Marital Status  1 ☐ Never Married 3 ☐ Widowed 4 ☐   |                              | 12. Was Decedent<br>Armed Forces?<br>1 K Yes 2 ☐ I<br>if Yes, Give<br>Year or Dates: |                               | - 1                 | Was Decedent of I<br>If Yes, specify Cub<br>1 □ Yes 2 ☑ No | dispanic Origin? (Spi<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No<br>Rican, etc.) |                               | 14. Race - Amer<br>Black, White<br>Specify: W |                          |               |  |
| 2-0                        | 72 ho   | eted                | 15<br>(Specify  | . Decedent's Ed              | lucation<br>de completed)  | 1                             | 6a. Dece            | dent's Usual Occup   | oation<br>during most of work                            | ina                             | 16b. Ki                       | nd of Business/I                              | ndustry                  |               |  |
| 2                          | within ene.   | Completed           | Elementary/Seconda  |                              | College (1-4or 5   | , I                           | life. i             | DO NOT use retire  | d)   | nig                             |                               |   |                          |               |  |
|                            | e filed wall Hygier I other the   |                     |   |                              |  |                               |                     |  | - /Fire 0 0 d d d  | Stone Quarry                    |                               |   |                          |               |  |
| and<br>E                   | be fil<br>d otl   | Be                  |   | ·                            |  |                               |                     |  | 18. Mother's Name  |                                 |                               |   |                          |               |  |
| <u> </u>                   | 2 should be and Mental is marked (raumatic ev   | 2                   | William Franklin Peacock  Cather:  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Ru  |                              |  |                               |                     |  |  |                                 | Gerwig<br>Gerwia              |   |                          |               |  |
| , Maryland                 | 2 # 7 # B   |                     | Helen Pea   |                              |  |                               | 100                 | 009 Produ  | cts Dr.,   |                                 |                               |   |                          |               |  |
| Baltimore,                 | Pages 1 ar  |                     | 20a. Method of Disposi<br>1 XBurial 2 □C  |                              | Removal from State   |                               |                     | osition (Name of<br>matory or other pla                    |  | 13/08                           |                               | cation - City or 1                            |                          |               |  |
| Ħ                          | permit. Pages<br>Department of<br>Important: If it<br>any Injury or once.   |                     | 4 Donation 5 [<br>21. Signature of 5 wer  |                              | 1 1/1/   | ,   Dula                      |                     | Valley M<br>2. Name and Addre                              | emorial G  | ardens                          | Timo                          | nium, M                                       | D                        |               |  |
| Ba                         | Depa<br>Impo<br>any I   |                     | 11110   | J. Fla                       | Mugh   |                               |                     | Lemmon F   | uneraĺ Ho  | me of D                         | ulan                          | ey Vall                                       | ey, In                   | c.            |  |
|                            |   |                     | 23a. Part1. Enter the c<br>shock, or heart fa   |                              |  | the death. D                  | o not ent           | ter the mode of dyi  | nia Rd.,<br>ng, such as cardiac                          | T1mon1u<br>or respiratory a     | m •M<br>rrest,                | D_21093                                       | Approxima                | ite           |  |
|                            | Physician   | 0 0                 | Immediate Cause (Final  |                              | one cause on each III  | ne.                           | 1011                | 11/5/  | MANCIA   |                                 |                               | 1   | Interval Be<br>Onset and | Death         |  |
|                            | /Medical  |                     | Immediate Cause (Final disease or condition resulting in death)  a. ASURATION INEUMONIA  Due to (or as a consequence of):  Sequentially list conditions,  b. URINATU THECTION  DATE |                              |  |                               |                     |  |  |                                 |                               |   |                          |               |  |
|                            | Examiner  | URINARY THACT INF   |   |                              |  |                               |                     | FECTION  | /  |                                 |                               | DAY.  | 5                        |               |  |
| 16                         | D #   | ner                 | Sequentially list condit<br>if any, leading to imme<br>cause. Enter Underlyin<br>Cause (Disease or inju-  | ediate                       | Due to (or as  | a consequen                   | ce of):             | 0  | ·  |                                 |                               |   | 1111                     | 1 10 0        |  |
|                            | nd<br>rransi  | Examiner            | Cause (Disease or inju<br>that initiated events<br>resulting in death) Last   |                              | c. SIRC  | RE,                           | ML                  | UTIPLE   |  |                                 |                               |   | JZ#1                     | 725           |  |
| 60,                        | tificate be executed<br>g physician and<br>as the burial-transit  |                     | resulting in death / Last   |                              | Due to (or as  | a consequen                   | ce of):             |  |  |                                 |                               |   |                          |               |  |
| 68760,                     | cate t  | edical              |   |                              | d  |                               |                     |  |  |                                 |                               |   |                          |               |  |
|                            |   | 4000                | IF FEMALE:  |                              | 23c. If yes, outcome   | of pregnancy                  | ,                   |  |  |                                 |                               | Od Data of dali                               |                          | 3008-         |  |
| Box                        | leath cer<br>attendin<br>for use  | cian                | 23b. Was decedent pro<br>in the past 12 mo  | nths?                        | 1 ☐ Live birth<br>4 ☐ Pregnant at  | 2 Fetal de                    | ath 3[              | ☐Ectopic pregnanc<br>☐ Other <i>(specify)</i> _            | у  |                                 | 1                             | 3d. Date of deli<br>Month                     | very<br>Day              | Year          |  |
| P.O.                       | w requires that the death ce<br>been signed by the attendir<br>should be detached for use   | Physician/N         | 1 ☐ Yes 2 ☐ N<br>9 ☐ Unknown  | 0                            | 9☐Unknown  |                               |                     | _ onlor (opcoin)   |  |                                 |                               |   |                          |               |  |
|                            | that<br>ned b   | y V                 | Part II. Other significa  | nt conditions c              | ontributing to death b   | ut not resultin               | g in the u          | nderlying cause giv  | ven in Part I.   | 23e. Did t                      | obacco u                      | se contribute to                              | the cause of             | death?        |  |
| rds                        | quires<br>n sign<br>ald be  | Q D                 | DIABE   | 165                          |  |                               |                     |  |  | 1 🗆                             | Yes 2[                        | □ No 3 □ Pro                                  | obably 4                 | Unknown       |  |
| 00                         |   | lete                |   |                              |  |                               |                     |  |  | 24a. Was                        |                               | 24b. Were au                                  | topsy findings           | available     |  |
| Re                         | : The law<br>cate has b<br>, page 2 sl  | Completed by        |   |                              |  |                               |                     |  |  | auto                            | psy<br>rmed?<br>2 <b>20</b> 0 | I prior to c                                  | ompletion of a<br>2 □ No | cause of      |  |
| ta                         | (0 11   | Be C                | 25. Was case referred   | to medical                   |  |                               |                     | <u> </u>   | 26. Place of Deat  |                                 |                               | I I I I es                                    | 2 110                    |               |  |
| <u> </u>                   | Physiclan: this certific ral director,  | To B                | examiner?<br>1 ☐ Yes 2 ★ No   |                              | Hospital: 1 ☐ Inpatie  | ent 2 ER/                     | Outpatier           | nt 3 DOA Oth   | ner: 4 Nursing Ho  |                                 |                               | Sother (Spec                                  | eity) HOS                | PICE          |  |
| 0                          | ng Pt<br>fter th  |                     | 27. Manner of eath  | 5 ☐ Pending                  | 28a. Date of Inju<br>(Month, Da  |                               | b. Time o<br>Injury | f 28c. Inju  | ry at<br>rk?   | 28d. Describe                   |                               |   |                          |               |  |
| <u>Si</u>                  | Attending r death. ector: After by the funer  | atic                | 2 ☐ Accident  | investigation                |  |                               |                     |  | Yes 2□No   |                                 |                               |   |                          |               |  |
| Division or Vital Records, | or Att  | Certification:      | 3 ☐ Suicide 6<br>4 ☐ Homicide   | 6 Could not be<br>determined | Zoe. Flace of mi   | ury - At home<br>c. (Specify) | , farm, str         | reet, factory, office                                      |  | 28f. Location (<br>City or To   | Street and<br>wn, State       | d Number or Ru<br>)                           | ral Route Nur            | mber,         |  |
|                            | urs all   |                     | 00 0 117  | 70                           |  | .6                            |                     |  |  |                                 |                               |   |                          |               |  |
|                            | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.                  | Medical             |   |                              | ysician: To the best<br>niner: On the basis o<br>and manner st                       | f examination                 |                     |  |  |                                 |                               |   |                          | (s)           |  |
|                            | To the within 2 To the complex  | Me                  | 29b. Signature and title  | of certifier                 | 5  |                               |                     | 29c. Licens  |  |                                 | 29d. Dat                      | e signed (Month                               | Day, Year)               | Q.            |  |
|                            |   |                     | A   | 24                           | 1/1/   | 1                             |                     | 106  | 4395   |                                 | 128                           | RUARY   | 8,200                    | <del>८8</del> |  |
| /                          | 411)  |                     | 30. Name and address  | of person who                | completed cause of d   | leath (Item 23                | a) (Type,           | Print)   | Civity   | 2 00                            | as;                           | Timone  | 111212                   | 04            |  |
|                            |   |                     | DANIEUE 31. Date filed (Month,  | DOBERI                       | MANIMO (   | ar's Signature                | NC                  | HAKUESS  | il, sull'E   | 204                             | One                           | TITIONE;                                      | nvalo                    | - 1           |  |
| (3)                        | Sta<br>Registi  |                     |   |                              | 2008   | ar's Signature                | 2 4                 | Carte  |  |                                 |                               |   |                          |               |  |
| Di                         | MH 17 Pay 1/2   |                     |   | TD 19                        | 2000   |                               | 10                  | 100  |  |                                 |                               |   |                          |               |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend #1,823a, perMD,g877, 3/4/08 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** *2008* 4a. Facility Name (If not institution, give street and number) Ruth Seitz Qualey /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Charlestown Care Center Catonsville Baltimore 8. Date of Birth (Month, Day, Year)

April 27,1920

Maryland Birthplace (State or Foreign Country) If Under Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1 M 2 XF Yrs April Director 220-09-0880 87 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 709 Maiden Choice Lane RGS402 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White If Yes, Give Year or Dates: ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other trainment. College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon William Seitz Kathleen Imelda Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6140 Regent Park Road; Catonsville, MD 21228 Kathleen Bankert Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Metro Crematory 2/15/2008 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licens Musan 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVD **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Box 68760, attending physician pe Physician/Medical the as IF FEMALE: for use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ş cate has been sig , page 2 should b 1 Yes 2☐No 3☐ Probably 4☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1∐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ Ne 1 Inpatient 2 ER/Outpatient 3 DOA 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) r 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No spital or Attendliours after death.
neral Director: A death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier UND 200 8

State Registrar 31. Date filed (Month, Day, Year) 33-Re FEB 1 5 2008

9216

30. Name and address of

son who completed ceuse



of deeth (Item 23a) (Type, Print)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. LOSENBERGER Baltimore, Maryland 21215-0036 LAWRENCE

**Funeral** Director

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Physician

|                | 1. Decedent's Nam  | e (First, Middle,        | Last)  |                                   |                       |  |                         | 2. Date of Month                          | Death<br>Da                 | v Vear                                 | 3. Time of Death                    |
|----------------|--|--------------------------|--|-----------------------------------|-----------------------|--|-------------------------|---|-----------------------------|--|-------------------------------------|
| ian<br>cal     | Lawren   | nce Geo                  | orge Rose  | nberge                            | er                    |  |                         | Telm                                      |                             | 2008                                   | 4. 15A.M                            |
|                | 4a. Facility Name (/   | f not institution, g     | give street and number                           | )                                 |                       | 4b. City, Town, or                     | Location of D           |   |                             | . County of Death                      | ١                                   |
|                | Baltimon   | e Wash                   | nington M  | ed Cti                            | <u> </u>              | Glen                                   |                         |   |                             | Anne Ar                                |                                     |
|                | 5. Social Security N   |                          | . Sex 7. A                                       | ge (In yrs. last                  |                       | If Under 1 Year<br>Months Days         | If Under 24<br>Hours    | Hrs. 8. Date of<br>Min. (Month,           | Birth<br>Day, Year,<br>7/19 | 9. Birth                               | nplace (State or Foreign<br>untry)  |
|                | 215-14-0   |                          | TE WIZET   | 86                                | Yrs.                  |  |                         | 09/2                                      | 7/19                        | 21                                     | MD                                  |
| 1              | Usual Residence of<br>10a. State                               | 10b. County              |  | 10c. City, T                      | own or Loc            | ation                                  |                         |   |                             |  | 10d. Inside City Limits             |
| 5              | MD   |                          | Arundel  |                                   | sader                 |  |                         |   |                             |  | 1 ☐ Yes 2 ☑No                       |
| Director       | 10e. Street and Nu   |                          | Ardider  | Tas                               | adei                  | 10f. Zip Code                          |                         |   | 10a. Ci                     | tizen of What Co                       | untry?                              |
|                |  | Gallati                  | n Way  |                                   |                       | 211:                                   | 2.2                     |   |                             | U.S.A.                                 |                                     |
| Funeral        | 11. Marital Status   |                          | 12. Was Deceden                                  | t Ever in U.S.                    | 13. W                 | <u> </u>                               |                         | n? (Specify Yes or<br>Puerto Rican, etc.) | No-                         | 14. Race - Amer                        | rican Indian,                       |
| 표              |  | ried 2 Married           | Armed Forces d 1 ☐ Yes 2 ☑                       |                                   |                       |  |                         | Puerto Rican, etc.)                       | )                           | Black, White                           | e, etc.                             |
| ğ              | 3 ☐ Widowed  | 4 Divorced               | If Yes, Give<br>Year or Dates                    |                                   | 1                     | ☐ Yes 2 No                             | Specify:                |   |                             | Specify:<br>Wh                         | nite                                |
| Completed      | (Sne   | 15. Decedent's           | Education grade completed)                       | 1                                 | 6a. Decede            | ent's Usual Occup                      | ation<br>during most of | f working                                 | 16b. F                      | (ind of Business/I                     | ndustry                             |
| g .            | Elementary/Second  |                          | College (1-4or                                   | 5+)                               |                       | ind of work done<br>O NOT use retired  |                         | ,g  |                             | D 011                                  |                                     |
| ပြွ            | 12   | <u> </u>                 |  |                                   | Truc                  | k Driv                                 |                         |   | <u>B</u>                    |  |                                     |
| Be             | 17. Father's Name  |                          |  |                                   |                       |  |                         | Name (First, Mio                          |                             | n Surname)                             |                                     |
| <u>٩</u>       |  | Rosenbe                  |  |                                   |                       |  |                         | nna Lye                                   |                             |  |                                     |
|                | 19a. Informant's N   |                          |  |                                   | `                     | •                                      |                         | or Rural Route Nu                         | -                           |  |                                     |
|                |  |                          | / Niece  |                                   |                       |  |                         | y Dr., A                                  |                             | ocation - City or                      |                                     |
|                | 20a. Method of Dis<br>1 Burial 2                               |                          | B □Removal from Stat                             | e 1                               |                       | ition (Name of<br>atory or other place |                         |   |                             | •                                      |                                     |
|                |  | 5 Other (Spe             |  | Holy                              | / Red                 | eemer C                                | em   02                 | 2/14/08                                   | Ba                          | ltimore                                | e, MD                               |
|                | 21. Signature of E   | Pieral Service Li        | censee   |                                   |                       |  |                         |   |                             |  | Home, PA                            |
| $\square$      | /he  | 1/20-                    |  |                                   |                       |  |                         | rive, P                                   |                             | ena, MD                                | Approximate                         |
|                |  |                          | omplications that cause<br>nly one cause on each | line.                             | No not ente           |  |                         |   |                             |  | Interval Between<br>Onset and Death |
|                | Immediate Cause<br>disease or condition<br>resulting in death) | on                       | _a ather   | delen.                            | tie                   | Candhi                                 | Vanu                    | lar a                                     | hs u                        | ne                                     |                                     |
|                | resulting in death)  | -                        | Due to (or a                                     | s a consequer                     | ice of):              |  |                         |   |                             |  |                                     |
| <u>_</u>       | Sequentially list co   | onditions,               | b  | s a consequer                     | es effe               |  |                         |   |                             |  |                                     |
| nin.           | cause (Disease or  | erlying                  |  |                                   | ,                     |  |                         |   |                             |  |                                     |
| Examiner       | that initiated event<br>resulting in death)                    | S 🔳                      | c<br>Due to (or a                                | s a consequer                     | nce of):              |  |                         |   |                             |  |                                     |
|                |  |                          | d  |                                   |                       |  |                         |   |                             |  |                                     |
| edi            |  |                          | u.   |                                   |                       |  |                         |   |                             |  |                                     |
| cian/Medical   | IF FEMALE:<br>23b. Was deceder                                 | nt pregnant              | 23c. If yes, outcom                              |                                   |                       |  |                         |   |                             | 23d. Date of del                       | ivery                               |
|                | in the past 12<br>1 ☐ Yes 2                                    | 2 months?                | 4□Pregnant                                       | at time of deat                   |                       | Ectopic pregnancy<br>Other (specify)   | y<br>                   |   | _                           | Month                                  | Day Year                            |
| Physic         | 9 □ Unknowr  |                          | 9∏Unknown  |                                   |                       |  |                         |   |                             |  |                                     |
| by P           | Part II. Other sign  | ificant condition        | s contributing to death                          | but not resulting                 | ng in the un          | derlying cause giv                     | ren in Part I.          | 23e. D                                    | Did tobacco                 | - 1                                    | the cause of death?                 |
|                |  | bels                     | m-elho   |                                   |                       |  |                         | _   1                                     | I ☐ Yes                     | 2□ No 3 Pr                             | obably 4 Unknov                     |
| Completed      | `  | maen                     | renston.   |                                   |                       |  |                         | 24a. V                                    | Was an autopsy              | 24b. Were au                           | topsy findings availat              |
| E O            |  | 1/4                      |  |                                   |                       |  |                         | 1 7                                       | performed?                  | death?                                 | ·                                   |
| Be C           | 25. Was case refe  | rred to medical          |  |                                   |                       |  | 26. Place of            | f Death (Check or                         | <del>/</del> \              |  |                                     |
| 0              | examiner?  | No                       | Hospital: 120npa                                 | tient 2 EP                        | t/Outpatient          | 3□ DOA Oth                             | er: 4 🗆 Nurs            | ing Home 5 🗆 F                            | Residence                   | 6 □Other (Spe                          | cify)                               |
| Ë              | 27. Manner of Dea  | ath<br>5 ☐ Pending       | 28a. Date of Ir<br>(Month, L                     | jury 21<br>Day Year)              | Bb. Time of<br>Injury | 28c. Inju                              | ry at<br>rk?            | 28d. Descr                                | ibe how inj                 | ury occurred                           |                                     |
| atio           | 2 Accident   | investiga                | ition  |                                   |                       |  | Yes 2 □ No              | •   |                             |  |                                     |
| 0              | 3 ☐ Suicide  | 6 ☐ Could no<br>determin | 28e. Place of I                                  | njury - At home<br>etc. (Specify) | e, farm, stre         | et, factory, office                    |                         |   | on (Street a<br>r Town, Sta |  | ural Route Number,                  |
| 1              | 4 ☐ Homicide   |                          |  |                                   |                       |  |                         |   |                             |  |                                     |
| Certification: | 4 ☐ Homicide   | 51                       |  |                                   | dreah anhe            | occurred at the ti                     |                         |   |                             | s) and manner as                       | s stated.                           |
|                | 29a. Certifier<br>(Check only                                  |                          | Physician: To the be-<br>xaminer: On the basis   | of examination                    |                       |  | opinion, death          | occurred at the t                         | ime, date a                 |  |                                     |
| edical         | 29a. Certifier<br>(Check only<br>one)                          | 2 Medical E              |  | of examination                    |                       | restigation, in my                     |                         | occurred at the ti                        |                             | nd place, and due                      | e to the cause(s)                   |
| dical          | 29a. Certifier<br>(Check only                                  | 2 Medical E              | xaminer: On the basis                            | of examination                    |                       |  |                         | _   | 29d. D                      | nd place, and due<br>eate signed (Mont | th, Day, Year)                      |
| edical         | 29a. Certifier<br>(Check only<br>one)                          | 2 Medical E              | xaminer: On the basis                            | of examination                    |                       | restigation, in my                     |                         | _   | 29d. D                      | nd place, and due<br>eate signed (Mont | th, Day, Year)                      |
| edical         | 29a. Certifier<br>(Check only<br>one)                          | Medical E                | xaminer: On the basis                            | of examination stated.            | n and/or inv          | 29c. Licens                            |                         | _   | 29d. D                      | nd place, and due<br>eate signed (Mont | e to the cause(s)                   |

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** William Roelke FEBRUARY 12 2008 2:40 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHABILITATION FOREST HILL HARFORD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 XM 2 1 Director 317-44-0467 64 July 20, 1943 D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Harford Forest Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 109 Forest Valley Drive 21050 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married I TYes 2 No I Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chemist Science 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Milburn (nmn) Roelke Eleanor (unk) Reed ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gina Shaffer / POA 207 Fulford Avenue, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of P Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Greenwood Cemetery Michigan City, Indiana 4 Donation 5 Dother (Specify) UNK 21. Signature of Mal Sepace Licenses 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (\*r as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit and Due to (or as a consequence of). P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 0 in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9☐Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ pe 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy performed? certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

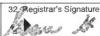
411

State 31. Date filed (Month, Day, Year)
Registrar

5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008



DAVID DUNN - 615 W. MACPHAIL ROAD - BEL AIR, MD 21014



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \( \) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5 20 Year **Physician** AM MARIE CATHERINE RIDGAWAY February 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bel Air Health and Rehabilitation Ctr. Hourfor Air If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🔀 F 1912 215-09-0368 95 May 6, Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 102 Meadow Road 21014 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: \$ 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Victoria (nmn) Cardia ပ Nunzio Charles Maranto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Carolyn Marie Goldstraw / Daughter 102 Meadow Road, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2-15-08 New Cathedral Cem. Baltimore, Maryland 21. Signature of Funeral Service Lieunsee McComas Funeral Home, P.A. Part1. Enter the disease, or composhock, or heart failure. List only of 1317 Cokesbury Road, Abingdon, Maryland 21009 cations that caus Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 51 cons of ence of): /Medical Due to (or a Examiner Sequentially list conditions, if an, leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence 1) Examine The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 9 I Inknown 9 ☐ Unknown Part (Other significant conditions continuing to death but not resulting and enderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ò icate has been sig , page 2 should b 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 **/**No Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 1 🗆 Yes 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural
2 Accident 5 Pending investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

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29b. Signature and title of certifier

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2008

of person who completed cause of death (Item 23a) (Type, Print)

8 (Jususs

Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

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|-----------------------|------|---|---|-------|---------|--|-----------------------------|-------------------------------|---------------------------|
|                       |      | For   | State of Maryla                         | and / | Depa    | artment of Health and M                        | lental Hygie                | ene                           |                           |
|                       | 1-   | For<br>State<br>Registrar                                       |   |       | Ce      | rtificate of Death                             | Reg                         | 1. No. 2008                   | 0443                      |
| Physician<br>/Medical | 1. [ | Decedent's Name (First, Middle, Last)                           | DELAINE                                 | W.    | RO      | LLYSON   | 2. Date of Death<br>Feb. 14 | , <sup>Day</sup> 2008 Year    | 3. Time of Death 4:40 A M |
|                       |      | Facility Name (If not institution, give st<br>Tate Chesapeake H |   |       |         | 4b. City, Town, or Location of Death Linthicum |                             | 4c. County of Death Anne Arun | del                       |

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumattc event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

| ın<br>al                         | DELAINE W. ROLLYSON   | Feb. 14,                                  | 2008 Year                                       | 4:40 A M   |
|----------------------------------|---|---|---|--|
| er                               | 4a. Facility Name (If not institution, give street and number)  Tate Chesapeake Hospice House  4b. City, Town, or Location of Death  Linthicum  |   | 4c. County of Death                             |  |
|                                  | 220-66-6475 1□M 2区 F 30 Vm Months Days Hours Min.   | B. Date of Birth (Month, Day, Y) Sept 10, | ear) Cou  | place (State or Foreign<br>intry)<br>land          |
| ctor                             | 10a. State 10b. County 10c. City, Town or Location Severn   |   |   | 10d. Inside City Limits 1 ☐ Yes 2 X No             |
| al Dire                          | 10e. Street and Number 1441 Maryland Avenue 21144   | 10g                                       | . Citizen of What Cou<br>Yes                    | intry?   |
| by Fune                          | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Side Year or Dates:  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Rich 1 Yes, Side Year or Dates:                              | fy Yes or No-<br>ican, etc.)              | 14. Race - Ameri<br>Black, White<br>Specify: Wh |  |
| Be Completed by Funeral Director | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Homemaker  | 16  | b. Kind of Business/Ir<br>Housewife             |  |
| To Be C                          | 17. Father's Name (First, Middle, Last) Dixie Harris Wright  18. Mother's Name (First, Middle, Last) Bernic   | First, Middle, Ma                         | iden Surname)                                   |  |
| 8                                | 19a. Informant's Name/Relationship (Type. Print) Patrick R. Rollyson (Husband)  19b. Mailing Address (Street and Number or Rural F  |   |   | p Code)  |
|                                  | 20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory of other place)  Bayview Crematory, Inc. 2/1   | .   | c. Location - City or T $8a1 {	t timore}$ ,     |  |
|                                  | 21. Signature of Funefal Service Licensee Kevin E Ecker McCully-Polyniak Fu 3204 Mountain Rd.,  | neral Ho<br>Pasadena                      | ome P.A<br>21                                   | 122  |
|                                  | 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):   | ,   |   | Approximate<br>Interval Between<br>Onset and Death |
| ysician/Medical Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  |   |   |  |
|                                  | IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1  Yes 2 No 9  Unknown  23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown  23c. If yes, outcome pf pregnancy 1 Clive birth 2 Fetal death 4 Pregnant at time of death 9 Unknown |   | 23d. Date of deliving Month                     | very<br>Day Year                                   |
| ed by Ph                         | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  | 23e. Did tobac                            | cco use contribute to                           | the cause of death?                                |
| Completed by                     |   | 24a. Was an autopsy performe              | prior to co                                     | opsy findings available ompletion of cause of      |
| tion: To Be                      | 25. Was case referred to medical examiner?    Yes   2   No  |   |   | in Hospizations                                    |
| Medical Certification:           | 3 Suicide 6 Could not be  | If. Location (Stree<br>City or Town,      | et and Number or Rui<br>State)                  | ral Route Number,                                  |
| ledical                          | 29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.                                  | nd due to the cau<br>d at the time, date  | se(s) and manner as<br>e and place, and due     | stated.<br>to the cause(s)                         |
| 2                                | 29b. Signature and titre of certifier  29c. License number  | 7 F                                       | Date signed (Month                              | 14, 2008   |
|                                  | 38. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SCA SCA SCA SCA SCA SCA SCA SCA SCA SCA   | Dr, 78, G                                 | -len Burs                                       | · Nd-2106/   |
| e<br>ar                          | FEB 15 2008 Fegistra's Signature  |   |   | L  |

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State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 5:55 a <sup>M</sup> 12 June Rishel Feb. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 307 Gold Brush Way Pasadena If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2 KF Days Hours Director 215-12-9682 88 June 17,1919 Marvland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at X□Yes 2□No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3831 8th. Street 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 N/AHomemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 <u>Clarence</u> W. Grimes Frances Bowen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any Injury or other traum once. 7799 Tick Neck Road Pasadena, Maryland 21122
f Disposition (Name of Date 20c. Location - City or Town, State Edna V. Wajtkowicz (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 2/14/08 Brooklyn Park, Maryland 22 Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena. Maryland 21122 21. Signature of Funeral Service Licenses 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementi **Physician** Vears disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) ate has been signed by the aftending physician and page 2 should be detached for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 NO 25. Was case referred to medical examiner? Be Nieces 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🗹 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Pi within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

olvin

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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Medical

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PERMIN

Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Porty 59

Feb. 12,2008

For Ave Balfor, all di 21276

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MELVIN JAMES RUSEN 9:30 A M Feb. 2008 10. /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6700 Rapid Water Way, Unit 103 Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth July 23, 1924 9. Birthplace (State Mary) and 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 □ F Hours Director 216-18-6431 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any price. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6700 Rapid Water Way, Unit 103 21060 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □ Wes 2 □ No If Yes, Give Year or Dates: WW 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Underwriter Insurance Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Joseph Rusen Helen Hajba ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21060 19a. Informant's Name/Relationship (Type. Print) Nancy C. Rusen (WIFE) 6700 Rapid Water Wav, Unit 103 Glen Burnie, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc. 2/12/08 | Baltimore, Maryland 21. Signature of Ful Service Licensee McCuily-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 2 Kevin E Ecker 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 3 ☐ Probably 4 ☐ Unknown 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed 1□ Yes 2□No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No. ၉ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

31. Date filed (Month, Day,

Year)

2008

32. Registrar's Signature

08-01014 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Brenda M. Ruby 2008-04438 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Month Day February 4, 2008 **BRENDA Medical Examiner** MAE RUBY 1929 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 9. Birthplace (State or Days oreign Months Director Hours 216-88-7939 2 X X М 45 Jan. 16, 196 Country) MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shor Yes 2 XX No "natural", or items 23a or 28a-f shor Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Bygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 450 Henryton S. 20724 U.S.A. uneral 11. Mantal Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Never Married Yes 2 XXNo 屲 Widowed 4 XXDivorced If Yes, Give Year Yes 2xx No specify: Specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Grade 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Charles E. Roberts Oleta Faye Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul W. Ruby, Jr. 450 Henryton S. 20724 son Laurel, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 XXCremation 3 Removal from State Donation 5 Other Specify: West Arundel Crematory 2/12/2008 Odenton, Maryland 21. Signatu of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. / M01103 ) 313 Talbott Avenue Laurel, Maryland 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause of ch line Between Onset and /Medical a. Multiple Injuries Death Immediate Cause (Final disease **F**xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed attending physician and or use as the burial - transit nysician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Fetal death Month Day Year Pregnant at time of death 5 signed by the atte 1 Yes 2 No 9 🗸 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś Yes 2 ✔ No 3 Probably 4 Unknown ted has been 24a. Was an 24b. Were autopsy findings available Complet autopsy prior to completion of cause of performed? death? page ✔ Yes 2 1 🗸 Yes No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 Other 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Feb 4, 2008 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Pedestrian struck by auto Natural 1854 hrs Pending Yes 2 V No 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Rt. 175 & Pocomoke Dr., Jessup, Md. determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DHMH 17 Rev 1/2001 **OCME 2006** 

State

Registrar

A.L.

32 Registrar's Signature

Carle Carlo

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

February 5, 2008

Assistant Medical Examiner

2008

ea Min 30. Name and address of percon who completed cause of death (Item 23a)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB

Taple.

Lina Li. MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| 0 | C | $\cap$ | 0 | 0 | 1  | 1   | 0 | ( |
|---|---|--------|---|---|----|-----|---|---|
| 2 | U | U      | 0 | 0 | 14 | 6.5 | J |   |

|   |                | -For State amend #6<br>Registrar                                  | Per FH                          | G070 4                            | Certific                   | ate of                        | Death                           |                    |             |                                    | Reg. No.            | Moore             | U U          |   |
|---|----------------|---|---------------------------------|-----------------------------------|----------------------------|-------------------------------|---------------------------------|--------------------|-------------|------------------------------------|---------------------|-------------------|--------------|---|
| Physicia<br>ledical Exami   | ın/            | 1. Decedent's Name (First, Middl<br>Helen                         | e,Last)                         |                                   |                            | Rud                           | dlesd                           | en                 |             | 2. Date of De<br>Month<br>February | Day                 | Year              | 3            | Time of Death<br>2201 hrs                   |
| 1   |                | 4a. Facility Name (if not institutio                              | _                               | d number)                         |                            | 4t                            | . City, Town,<br>Baltimore      | or Location        |             |                                    |                     | County of         | Death        |   |
| Funeral   |                | 5. Social Security Number   | 6. Sex                          | 7. Age (Ir                        | yrs. last bit              | rthday)                       | If Under 1 Y                    | ear If Und         | ler 24Hrs.  | 8. Date of E                       | Birth (MM/I         | DD/YYYY)          | g. Birthp    | lace (State or Foreign                      |
| Funeral<br>Director   | - 1            | i de  | *** 2XX                         |                                   |                            |                               |                                 | ays Hour           |             | 1                                  |                     |                   | Coun         | try)  |
|   | -              | 220-22-1041 Usual Residence of Decedent                           | 1 M Z                           | ,F   - }                          | 30                         | Yrs.                          |                                 |                    |             | Oct1                               | 1 , 1 :             | 921               | Mai          | yland                                       |
| any   | -              | 10a. State 10b. County  |                                 | 100                               | . City, Towr               | or Locatio                    | n                               |                    |             |                                    |                     |                   |              | 0d. Inside City Limits                      |
| <u> </u>  | _              | Md. n/  | a                               |                                   | Ba1                        | timo                          | re                              |                    |             |                                    |                     |                   |              | 1 XXYes 2 No                                |
| ne Maryland<br>or 28a-f show<br>fied at once.   | 윉              | 10e. Street and Number  |                                 |                                   |                            | · I                           | 10f. Zip Code                   | )                  |             |                                    | 10g. Citiz          | zen of Wha        | t Countr     | y?  |
| he Minor 2  | Director       | 5014 East E   | ager S                          | treet                             |                            | ĺ                             | 2120                            | 5                  |             |                                    | U.S                 | S.A.              |              |   |
| with ns 23:   |                | 11. Marital Status  | 12. Was                         | Decedent Eve                      | er in U.S.                 | 13. Was                       | Decedent of                     | Hispanic Or        | igin? (Spe  | cify Yes or N                      | No-                 | 14. Race - White. |              | n Indian, Black,                            |
| death<br>or iten  | Funeral        | 1 Never Married 2 M   | airieu                          | ed Forces?                        | No                         |                               | s, specify Cub                  |                    |             | (ican, etc.)                       |                     | •                 |              |   |
| after<br>al", o   | by             |   | orced If Yes, Give<br>or Dates: | e Year                            |                            |                               | Yes 2X                          |                    |             |                                    |                     | Specify: V        |              |   |
| hours at<br>'natural  |                | 15. Decedent's Education (Spe                                     |                                 |                                   | ted) 16a                   |                               | s Usual Occu<br>st of working I |                    |             |                                    | 16b. K              | Kind of Busi      | ness/Ind     | ustry                                       |
| 36<br>in 72<br>han "  | Completed      | Elementary/Secondary (0-12)<br>9 t h                              | Colleg                          | ge (1-4 or 5+)                    |                            | Home                          | Make                            | r                  |             |                                    |                     | Own I             | Home         | ءِ ا  |
| -00;<br>I with<br>giene<br>fher t   | ē              | 17. Father's Name (First, Middle,                                 | . Last)                         |                                   |                            |                               |                                 |                    | er's Name ( | First, Middle                      |                     |                   |              |   |
| 215-0036<br>be filed within 7<br>ntal Hygiene.<br>rked other than   | Bec            | Sylvester S   |                                 |                                   |                            |                               |                                 | An                 | na B        | radle                              | y                   |                   |              |   |
| Z mag   |                | 19a. Informant's Name/Relations                                   | ship (Type, Print               | )                                 | 19                         | 9b. Mailing                   | Address (St                     | reet and Nu        | imber or Ru | ural Route N                       | umber, Ci           | ity or Town,      | State, Z     | Zip Code)                                   |
| MD<br>nd 2 sho<br>alth and<br>m 27 is<br>aumati   |                | Patricia Wip  | precht                          | /daugl                            |                            |                               |                                 |                    | oad .       |                                    |                     |                   |              |   |
| f Heal  |                | 20a. Method of Disposition  1 Burial 2 Cremation                  | n 3 Remov                       | val from State                    |                            | of Disposit<br>atory or other | ion (Name of<br>er place)       | cemetery,          |             | Date                               |                     | Location - C      | -            |   |
| Page<br>Page<br>nent o  |                | 4 Donation 5 Other S  |                                 |                                   | G1e                        | n Ha                          |                                 |                    | 2-1         | 5-200                              | 18G1                | en Bu             | ırn          | ie, Md.                                     |
| Baltimore,<br>permit. Pages I at<br>Department of Her<br>Important: If the  | Ì              | 21. Signature of Funeral Service                                  |                                 |                                   |                            |                               |                                 |                    |             |                                    |                     |                   |              | Home, PA                                    |
|   |                | 23a. Part I. Enter the disease, or                                |                                 | -1                                | death Do                   | 1                             |                                 |                    |             |                                    |                     |                   |              | 1.21222<br>Approximate Interval             |
| Physician<br>/Medical   |                | failure. List only one cause                                      | on each line.                   |                                   |                            |                               |                                 | ig, such as        | Cardiac or  | respiratory                        | arrest, sire        | JON, OF HOUR      | ` ]          | Between Onset and<br>Death                  |
| xaminer   | - [            | Immediate Cause (Final disease or condition resulting in death)   |                                 | clerotic Ca                       |                            | ular Dise                     | ase                             |                    |             |                                    |                     | _                 |              |   |
| Y   |                | Sequentially list conditions,                                     | b                               | uo u oonooqo                      | 0.100 0.71                 |                               |                                 |                    |             |                                    |                     |                   |              |   |
|   | Je.            | if any, leading to immediate cause. Linter Universitying Cause    |                                 | as a consequ                      | ence of):                  |                               |                                 |                    |             |                                    |                     |                   | į,           |   |
|   | Examiner       | (Disease or injury that initiated events resulting in death) Last | C                               | as a consequ                      | ence of):                  |                               |                                 |                    |             |                                    |                     |                   |              |   |
| cuted nd transit  |                |   | d                               |                                   |                            |                               |                                 |                    |             |                                    |                     |                   |              |   |
| 3760, ficate be executed g physician and site burial - transi   | n/Medical      | UNPENDED  | AMEND                           | ED                                |                            |                               |                                 |                    |             |                                    |                     |                   |              |   |
| 8760<br>ifficate b<br>ng physic   | /Me            | IF FEMALE:<br>23b. Was decedent pregnant in t                     |                                 | yes, outcome                      | of pregnanc                |                               |                                 |                    |             |                                    | 236                 | d. Date of d      | ,            |   |
| 68<br>certifi<br>ading  | ian            | past 12 months?   | '                               | ive birth<br>Pregnant at tim      | e of death                 | 2 Feta<br>5 Oth               | al death<br>er (Specify)        | 3 Ector            | oic pregnar | icy                                |                     | Month             | Da           | y Year                                      |
| Box 68<br>e death certi<br>the attending<br>ed for use as   | Physicia       | 1 Yes 2 V No 9 Un   | known g                         | Jnknown                           |                            | o Oui                         | er (opcony)                     |                    |             |                                    |                     |                   |              |   |
| P.O. Box 68 that the death certif ned by the attending detached for use as  |                | Part II. Other significant condi                                  | tions contributi                | ing to death bu                   | ut not resulti             | ing in the ur                 | nderlying caus                  | se given in l      | Part I.     |                                    |                     |                   |              | e cause of death?                           |
| ires that the signed by   | Completed by   |   |                                 |                                   |                            |                               |                                 |                    |             |                                    |                     |                   |              | bly 4 🗹 Unknown                             |
| cords<br>aw requi<br>has been<br>2 should   | lete           |   |                                 |                                   |                            |                               |                                 |                    |             |                                    | topsy               | pri               | ior to co    | psy findings available mpletion of cause of |
| tal Reco  | omp            |   |                                 |                                   |                            |                               |                                 |                    |             |                                    | rformed?<br>s 2 ✔ N |                   | eath?<br>Yes | 2 No  |
| al R<br>an: T<br>ertific<br>tor, p  | BeC            | 25. Was case referred to medica                                   |                                 |                                   |                            |                               | 26.PI                           | ace of Deal        |             | nly one)                           |                     |                   |              |   |
| 1 of Vital Records,<br>ling Physician: The law requir<br>After this certificate has been s<br>funeral director, page 2 should I | 0              | examiner?<br>1 ✓ Yes 2 No   | Hospital: 1                     | Inpatient                         | 2 ER/                      | Outpatient                    |                                 | Other <sub>4</sub> |             | Home 5                             |                     | ence 6 🗸          |              | Scene                                       |
| n of<br>ing Pl<br>After<br>funera   | n: T           | 27. Manner of Death  1 ✓ Natural 5 □ Pen                          | (1                              | Date of Injury<br>Month, Day,Year | 286                        | . Time of In                  | · ·   _                         | njury at Wo        |             | 28d. Describ                       | e how inj           | ury occurre       | d            |   |
| sior<br>ttend<br>death<br>ctor:<br>y the  | atic           |   | ding<br>estigation              |                                   |                            |                               |                                 | Yes 2              |             |                                    | (0)                 |                   |              | Doub Markey City                            |
| Division pital or Attendion ours after death. teral Director: /   | Certification: |   | ild not be                      | Place of Injury                   | / - At home,               | farm, stree                   | t, factory, offic               | e building,        | etc.        | or Town                            |                     | and Number        | r or Rura    | al Route Number, City                       |
|   |                | 29a. Certifier  | Physician: To the               | ecify)                            | novadode = =               | onth accur                    | and at the time                 | date and           | place and   | due to the cr                      | ause(s) or          | nd manner :       | as states    | 1   |
| To the Hos<br>within 24 h<br>To the Fur<br>completely   | Medical        | (Check only 1 Certifying Pone) 2 ✓ Medical Exa                    | miner: On the b                 | asis of examin                    | nowledge, d<br>ation and/o | r investigati                 | on, in my opir                  | nion, death        | occurred at | the time, da                       | ite and pla         | ace, and du       | e to the     | cause(s)                                    |
| To with   | Med            | 29b. Signature and title of certifi                               | and mag                         | ner stated.                       |                            | _                             |                                 | ense numb          |             |                                    |                     |                   |              | h, Day, Year)                               |
|   |                |   | 4 Cm                            | /                                 |                            |                               | 0.                              | C.M.E.             |             |                                    | Feb                 | oruary 13         | 3, 2008      | 3   |
| Ta  |                | 30. Name and address of person                                    | n who completed                 | cause of dear                     |                            |                               |                                 |                    |             |                                    |                     |                   |              |   |
|   |                |   | Chief Medic                     |                                   |                            |                               | reet, Baltir                    | nore, ME           | 21201       |                                    |                     |                   |              |   |
|   | tate           |   |                                 | 2. Registrar's                    | Signature                  | 0-                            | PP a                            |                    |             |                                    |                     |                   |              |   |
| Regis   | MET.           | EED 1 E   | 2002                            | 100                               | 4.5%                       | 10000                         | W. 1                            |                    |             |                                    |                     |                   |              |   |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                 |  |                 | State of Maryland / State of Maryland / State Amend #5 & 19a, perFH,g876, 2/15/08   | Certificate of L   | ealth and M<br>Death  | n                                | leg. No.                           | 08 0444   |
|-----------------|--|-----------------|---|--|---|----------------------------------|------------------------------------|---|
|                 | Physici<br>/Medic  |                 | 1. Decedent's Name (First, Middle, Last)  LORETTA DIANE SM  |  |   | 2. Date of Dea<br>Month          | Day Ye 29                          | ar 14 - 10 M  |
| -               | Examin<br>Funeral  | ier             | 4a. Facility Name (If not institution, give street and number)  Merry Medical Center  5. Sozii Security Number 6. Sex 7. Age (In yrs. last b.   | birthday) If Under 1 Year Months Days  | Location of Death    + i mere  If Under 24 Hrs.  Hours Min. | 8. Date of Birth<br>(Month, Day  | 1 9                                | Death  It imare City  Birthplace (State or Foreign Country)  ARYLAND                |
| Ľ.              | Director   |                 | 443 −62 −7962 1   | Yrs. Days  | 110010  | 02/05/1                          | .955 M                             | ARYLAND  10d. Inside City Limits  |
|                 | th the Mary<br>or 28a-f sho<br>or notified a   | Director        | MD N/A  10e. Street and Number  | BALTIMORE C  | ITY   | 1                                | 10g. Citizen of Wha                | <b>XX</b> Yes 2 □ No at Country?  |
| 20              | be filed within 72 hours after death with the Maryland Hygiene.  ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral D    | 4411 LIBERTY HEIGHTS AVE., APT.  11. Marital Status  1 X Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates: | 1 21207  13. Was Decedent of H If Yes, specify Cuba  1 Yes 2 No                                    | ispanic Origin? (Spe<br>in, Mexican, Puerto<br>Specify:     | ecify Yes or No-<br>Rican, etc.) | USA  14. Race - Black, 1  Specify: | American Indian,<br>White, etc.<br>BLACK  |
| 7               | I within 72 hou<br>jiene.<br>r than "natura<br>the Medical Er  | Completed       | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  | Sa. Decedent's Usual Occup<br>(Give kind of work done of<br>life. DO NOT use retired<br>ROOM ATTEN | during most of worki<br>i)                                  | ing                              | 16b. Kind of Busin                 | HOTEL CORP •  |
| ⊑               | 2 should be filed<br>and Mental Hygi<br>is marked other<br>raumatic event, t   | To Be C         | 17. Father's Name (First, Middle, Last) WALTER W. SMITH   |  | 18. Mother's Name<br>GLADYS S                               |                                  | Maiden Surname)                    |   |
|                 | s 1 and 2 should<br>f Health and Men<br>item 27 is marke<br>other traumatic  | ŀ               | Will Marior Sister SR LAWIN   | 9b. Mailing Address (Street 4807 BELLE AV  | ENUE, BAI   | TIMORE,                          | MD 2120                            | 7   |
| Baitimore,      | permit. Pages 1 Department of H Important: If ite any Injury or ott  | l ,             | 1 Burial 2 MCremation 3 Bemoval from State  | of Disposition (Name of tery, crematory or other place)  CREMATORY  22. Name and Addre             | 2/12/   |                                  |                                    | ILLE, MD  |
| ם<br>מ          | Depa<br>Impo<br>any I  |                 | 23a. Pan Facir the displase, or complications that caused the death stock, or heart facire. List only one cause on each line.   | 4600 LIBE  | RTY HEIGH   | ITS AVE,                         | , BALTIMO                          |   |
|                 | Physician and Medical by hysician and street purished is the burial-transit  | edical Examiner | Immediate Jause (Final  | ce of):  |   |                                  |                                    | Onset and Death   |
| .O. Box         | ath certif<br>ttending<br>or use as  | Physician/Med   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dec                                       |  | ,   |                                  | 23d. Date of Month                 |   |
| rds, r          | w requires that the de<br>been signed by the a<br>should be detached t   | þ               | Part II. Other significant conditions contributing to death but not resulting   | g in the underlying cause giv  | en in Part I.   | 23e. Did to                      | 24                                 | ute to the cause of death?  ☐ Probably 4 ☐ Unknown                                  |
| Vital Records,  |  | Completed       | 25. Was case referred to medical  |  |   | 1□ Yes                           | osy prio<br>ormed? dea<br>2 No 1   | ore autopsy findings available<br>or to completion of cause of<br>ath?<br>☑Yes 2☐No |
| DIVISION OF VII | Ing Phys<br>After this<br>uneral dii   | ation: To Be    | examiner? 1  Yes 2 No Hospital: 1 Inpatient 2 EP/   | b. Time of 28c. Injury Wor   | 4 LI Nursing Ho   | ome 5 Resid                      | dence 6 Other                      | · · · · · · · · · · · · · · · · · · ·   |
| DIVIS           | tal or Attend s after death al Director: , ed in by the f  | Certification:  | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)  | , farm, street, factory, office  |   | 28f. Location (8<br>City or Tox  | Street and Number<br>wn, State)    | or Rural Route Number,  |
|                 | To the Hospital or I within 24 hours after To the Funeral Direction completely filled in b   | edical          | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowler and manner stated.   | and/or investigation, in my  | opinion, death occur  | rred at the time,                | date and place, an                 | nd due to the cause(s)  |
| (               | )<br>S o o o   | Σ               | 29b. Signature and title of certifier  ARVIND B.A.  |  | 1965E   | <                                | 29d. Date signed (                 |   |
| _               | D  |                 | 30. Name and address of person who completed cause of death (Item 23  ARVIND BAKHRU 90  | SERCY THE  | Har S   | GATE                             | BACTO,                             | MD 21202  |
|                 | St<br>Regist   | ate<br>rar      | 31. Date filed (Month, Day, Year)  FFR 1 5 2008  32. Registrar's Signature  | document.  |   |                                  | ,                                  |   |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Alice C. Scott 14, 2008 3:00 February Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 211 Osborne Avenue Catonsville Baltimore 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 □ M 2 X F Director 220-12-8081 99 June 1, 1908 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 211 Osborne Avenue 21228 USA by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nd 2 should be fi lith and Mental H 27 Is marked ot r traumatic ever Reuben D. Shifflett Virginia Moubray ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heath ar Important: If item 27 Is any injury or other trau <u>Janet C. Shelton</u> Daughter 211 Osborne Avenue; Catonsville, Maryland 21228 altimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Good Shepherd Cemetery 2/16/2008 Ellicott City, Maryland 21. Signature of Funeral Savins Licence 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** corre /Medical Due to (or nsequence of) as a o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760, attending physician as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) P.O. | signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2√√No 24a. Was an certificate has the inector, page 2 s autopsy perform a√Z No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 N Residence 6 ☐ Other (Specify) Certification: To this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 162 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 405 Frederick Road; Catonsville, MD 21228 Patrick White, M.D., 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

**Physician** /Medical

Division or Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit

Physician/Medical

þ

Completed

Be

ဥ

Certification:

Medical

as

| 23a. Part1. Enter the disease, or of shock, or heart failure. List of                               | complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,<br>inly one cause on each line. |
|---|---|
| Immediate Cause (Final disease or condition resulting in death)                                     | a Renal Failure   |
| Sequentially list conditions,   | Due to (or as a consequence of):  b. Thy dra trin   |
| if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to for as a consequence of):  |
| resulting in death) Last  | Due to (or as a consequence of):  |
|   |   |

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

Year

weeki

weeks

weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an performe

1 Tes

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28h Time of

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

2 Accident

3 ☐ Suicide

4 ☐ Homicide

CUP D

PSOUD

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

29c. License number 1) 31295

Sute 4202

29d. Date signed (Month, Day, Year)

21204

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N charles St Kloesz

31. Date filed (Month, Day, Year)
FEB 1 5 2008

32. Registrar's Signature

Registrar

To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** peranzella AntoneHe 2XX /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Parknag Baltonone Parks 14 Crenesis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Months 1 □ M 2 🗹 F 94 Director 213-01-4789 Nov. 13,1913 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Marvland Baltimore Overlea 1 ☐ Yes 2 X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4321 Belmar Avenue 21206 U.S.A. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White 3 X Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Costantini Ernanni Caterina Rosasco ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James T. Speranzella - Son 4321 Belmar Ave. Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Feb. 18, 2008 Baltimore, MD Gardens of Faith 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Maryland 5305 Harford Rd. Leonard J. Rück. Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years CHE /Medical Due to (or as a consequence of): Examiner RSCOO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician ned for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 16, due Be Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 Dm 2 4 No or Attending Physiclan: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 31291 2/13/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St Suite 4202 md 21201 Kloesz 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U S Certificate of Death 3. Time of Death 2. Date of Death -Month **Physician** Shropshire ebruari /Medical 4c. County of Death 4a. Facility Name, (If not institution, give street and number Town, or Location of Death Examiner Hrs. /8. Date of Birth Min. /Month, Day, Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2 🗸 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other then "neturel", or items 23a or 28e-1 show or other treumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Yes 22No Specify Completed by 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other then any injury or other treumatic event, the Me. Elementary/Secondary (0-12) College (1-4or 5+) ther's Name (First, Middle, Last) Be 19a. Informant' 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 □ Яе moval from State 4 □ Donation 5 □ Other (Specify) 21. Signa e of Funeral Service Licensee u Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initials are sequentials). Due to (or as a consequence of) Examiner use as the burial-transit that initiated events resulting in death) Last ettending physicien and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Cther (specify) this certificate hes been signed by the ral director, page 2 should be deteched 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 dinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: In the manner of the within 24 hours efter death.

To the Funeral Director. After this certific commission filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 D No 1 Thipatient 2 ER/Outpatient 3IT DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending М 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of pertifier person who complet ed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death CARSON CRAIG SPITZLER **Physician** 6.20 A tebruary 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Anne Arunde Batimore Washington Medical Cente Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6 30 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours Min 1 XM 2 ☐ F 72 Dec 5. Maryland Director 213-32-2337 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County a or 28a-f show t be notified at 1 ☐ Yes 2☑ No Director Anne Arundel Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21226 ms 23a c 600 Water View Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status ו "natural", or item: edical Examiner וו 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: 2 White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene.
Int: If Item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Factory Laborer 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Pitzinger George Spitzler ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 Is any Injury or other trau 405 Townsend Ave., Baltimore, Maryland 21225 Cindy Keefe (daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Glen Burnie, Maryland Glen Haven Mem Pk 2/12/08 4 Donation 5 Other (Specify) 21. Signature of Fungital Service Licensee Kevin E McCully-Polyniak Funeral Home, P.A. Ecker 21225-1856 237 F. Patapsco Ave., Balto., Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 83STRUETINE CHRONIE Um 5 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ONGEGNUE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or a a consequence of): Examine certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Ves 2 No page 2 s has certificate 1□ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 27. Man er of Death 1 ✓ Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d Describe how injury occurred Certification: (Month, Day Year) Iniun 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signa and title of certifier Mis 200

Registrar

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State

arson Spitz

20161

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month BONNIE Year MAE SCHWING 1937PM. FEB 2008 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death HUWARD COUNTY GENERAL HOSPITAL COLUMBIA HOW ARD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2√X 216-52-0800 May 12, 1948 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8312 Lark Brown Road 21045 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XXo If Yes, Give 1 ☐ Never Married 2XXMarried 1 ☐ Yes 2 🖾 📉 o Specify. Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
Grade 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Preston Robert Holmes Thelma Edna Souder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, Maryland 21045 8312 Lark Brown Road Henry Schwing spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State West Arundel Crematory 2/14/08 Odenton, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) weeks Kesniraton Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last neumonia Due to (or as a consequence of) Due to (or as a consequence of):

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

MD

Director

Funeral

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Completed

Be

**Funeral** 

Director

physician and s the burial-trans as use To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

Examiner dical

Me

State Registrar 29b. Signature and title of certifier

5

31. Date filed (Month, Day

MD, FCCP

32. Registrar's Signature

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

2008

| hysician/Me  | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?<br>1 □ Yes 2 ☑ No<br>9 □ Unknown | 1 □ l<br>4 □ F | s, outcome pf pregna<br>Live birth 2☐Feta<br>Pregnant at time of c<br>Unknown | al death 3 □E          |           | pregnand<br>(specify) _   | су  |                            |                              | )                       | ate of delivery<br>onth Day                                     | Year             |
|--------------|---|----------------|---|------------------------|-----------|---------------------------|---|----------------------------|------------------------------|-------------------------|---|------------------|
| <u> </u>     | Part il. Other significant condition  | s contributing | to death but not res  | ulting in the und      | erlying   | q cause gi                | iven in Part I.                             | 23e                        | . Did tobacc                 | o use con               | tribute to the car  | use of death?    |
| eted by      | bronchieda  | sio,           | sepsi   |                        |           | na                        |   |                            | 1 🗆 Yes                      | 2 No                    | 3 ☐ Probably  | 4 □Unknowi       |
| complet      | chronic mye   | loge.          | 1. coli   | leuke<br>trs           | m'        | 50,                       | Theuma                                      | ina                        | . Was an autopsy performed;  | 2                       | . Were autopsy fi<br>prior to completi<br>death?<br>1 ☐ Yes 2 ☑ | tion of cause of |
| e            | 25. Was case referred to medical  |                | 1   | 1.2                    |           |                           | 26. Place of Dea                            |                            |                              |                         |   |                  |
| 0 B          | examiner?<br>1 ☐ Yes 2 No   | Hospital:      | 1 Inpatient 2 □   | ER/Outpatient          | 3 🗆 [     | DOA Ot                    | ther: 4 Nursing H                           |                            |                              | 6 □Otl                  | her (Specify)   |                  |
| rtification: | 27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigat                                  |                | Date of Injury<br>(Month, Day Year)   | 28b. Time of<br>Injury | М         | 28c. Inju<br>Wo<br>1      | ury at<br>ork?<br>] Yes 2 □ No              | 28d. Des                   | cribe how ir                 | ijury occui             | rred  |                  |
| Certific     | 3 ☐ Suicide 6 ☐ Could not determine   | ∠6e. I         | Place of injury - At ho<br>building, etc. (Specil                             | ome, farm, stree       | t, facto  | ory, office               | 9   | 28f. Loca<br>City          | ition (Street<br>or Town, St | and Numi<br>ate)        | ber or Rural Rou  | ite Number,      |
| dical        | 29a. Certifier 1 Certifying (Check only one) 1 Medical Ex   | caminer: On    | To the best of my know<br>the basis of examina<br>manner stated.              | wledge, death outline  | stigation | ed at the t<br>ion, in my | time, date and place<br>opinion, death occi | e, and due<br>urred at the | to the cause<br>time, date   | e(s) and m<br>and place | anner as stated.<br>, and due to the                            | cause(s)         |

29c. License number

D36845

11106

29d. Date signed (Month, Day, Year)

K11),

Feb 12, 2008

DHMH 17 Rev 1/2001

Coter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 7 Month TEBRUARY Day Physician ELMER CARL STONESIFER 138 A M 13 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER MEDICAL BALTIMORE GLEN IJURNIE ANNE WASHINGTON ALUNDEL Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 219–32–3439 **Funeral** Months Days Hours 1 🕱 M 2 🗆 F 71 Director Aug. 10, 1936 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notified at Pasadena Anne Arundel 1 ☐ Yes 2 No Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code mportant: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I USA 196 Magothy Beach Road 21122 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2K Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 White 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist Repairman Glass Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 Is marked of Charles Stonesifer Addie Doris Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rosalie E. Stonesifer (Wife) 196 Magothy Beach Rd., Pasadena, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Mem. Pk. Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/18/08 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) Kevin E Ecker 21. Signature of Fundral Service Licensee 22 Name and Address of Facility ak Funeral Home. P.A. 3204 Mountain Rd., Pasadena, Md. 21122 Approximate Interval Between Onset and Death 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEMONIA **Physician** /Medical Due to (or as a consequence of): Examiner 504413 Sequentially list conditions, if any, leading to immediate cause. Enter United Sequences (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed the burial-transit TONGUE ag/ Due to (or as a consequence of) Box 68760. physician Physician/Medical as 1 attending IF FEMALE: nse If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) P.O. the a 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform 1 ☐ Yes 2 No Division or Vital 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No 1 Inpatient 2 TER/Outpatient ပ္ 3 DOA this 27. Mann Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 atural (Month, Day Year) Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of contifier

BALTMONE

31. Date filed (Month, Day, Year)

FEB

30. Name and address

ELMER

STONE SITER

MUDICAL

conon

person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

WASMINGOOM

2008

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29d. Date signed (Month, Day, Year)

GLOW BURNIC

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 02/10/2008 10:40a W. Shelton Scipio Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Southern MD Hospital Clinton If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 1 Year Days **Funeral** Months Hours 1**万**M 2□F 43 Yrs 04/15/1964 DĈ 577-94-0391 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1y Yes 2 No Washington Fort MD Prince Georges Directo 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 8920 Bluffwood Lane 20744 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐No Specify 9 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Accounting Supervisor Private 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hyglic Important: If item 27 is marked other t any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Creech Shelton W. Scipio Sr. Trene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shelton W.Scipio Sr. /Father 8920 Bluffwood Ln, Ft. Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cem. 02/15/08 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Hm. 21 Fignature o Funeral Service Licensee 108 West North Ave.Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Severe Right Ventricular Faihre Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical 23c. If ves. outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? Certification: Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State)

that the death certificate be executed P.O. Box 68760. physician the attending pl ed by the a signed t Records, page 2 s Division or Vital Hospital or Attending Physician:

filed within 72 hours after death with the Maryland

ene. than "

Maryland 21215-0036

Baltimore,

and burial-trar certificate this After n 24 hours atter death.

he Funeral Director: A
pletely filled in by the fi death.

3 Suicide

4 ☐ Homicide

29a. Certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of

M

D0055120

29d. Date signed (Month, Day, Year)

3. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) 1728 Janhen dienne SE faite 310 mil Palmer

31. Date filed (Month, Day, Year) 5

32, Registrar's Signature

State

within 2

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 11:00 AM 02 8 2008 RICHARD E. SCUDDER 0 /Medical 4c. County of Death N/A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Days 1**X** M 2□ F Months 75 Director 218-28-3582 AUG. 16,1932 NY Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10h County r 28a-f show notified at 1 DXYes 2 □ No Director MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 'natural", or items 23a or dical Examiner must be 5524 BUCKNELL RD 21206 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: WHITE 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Mental Hygiene. 8th GENERAL ELECTRIC ELECTRICAL MECHANIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MILDRED RACKETT CHARLES SCUDDER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALTIMORE, MD 21206 Department of Health a Important: If item 27 Is any Injury or other tra 5524 BUCKNELL RD DORIS SCUDDER-WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2/13/08 PARKWOOD CEMETERY BALTIMORE, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Funeral Service Licenses BALTIMORE, MD 21206 6415 BELATE RD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sume on each line. ASPIRATION PNEUMONIA Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical OROPHARYNGEAL DYSPHAGIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 CARD **4** ☑Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed COPD 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform page CAD 2 ✓ No this certificate 1☐ Yes or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Inpatient 2 28a. Date of Injury 28b. Time of n 24 hours after death.

The Funeral Director: After the steel of filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Division Natural Injury 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier and manner stated. To the 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 00066369 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PRIYANKA SOIN 5601, LOCH RAVEN BLVD, BALTIMORE, MD 21

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Begistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician OGER 10:08 AM tehnan 2008 u /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner ltinene Merces If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year 7. 9. 194 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**4** M 2□ F -40-37a8 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at Baltimore 1☐Yes 2☐No Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Ellwood Avenue ala13 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ģ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) and scaper Baltimore C 1147 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fill f Health and Mental H item 27 Is marked otl Be 19a. Informant's Name/Relationship (Type. Print) Lee Winston oretha 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health at Important: If item 27 Is any injury or other trau M Glen Burnie MD 21225 erm Cherry Hill M. Moore. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Memorial 2/21/08 Baltimore MI)
22. Name and Address of Facility Vaugna C. Greene Foreral Services Arbutus Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee . Greene Vaughout. Sheare 4905 York Ind Balthnore, Mi

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York And Baltimore, MIN Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LOUV /Medical Due to (or as a consequence of) Examiner asno lute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ( r as a consequence of) Examine executed burial-trar Due to (or as a consequence of): attending physician certificate be Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 I Inknown 9 DUnknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed? Yes 2 \sum No has certificate 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA ပ funeral 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

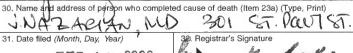
| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) and manner stated.

Box 68760 P.O. Records, Division or Vital

State Registrar 31. Date filed (Month, Day, Year)

2008

29b. Signature and title of certifie



29c. License number

Baltimore, ND

29d. Date signed (Month, Day, Year)

11,2008

08-01123 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Delroy D. Tinsley 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Physician/ 1. Decedent's Name (First, Middle,Last) 1123 hrs **Medical Examiner** February 8, 2008 Delroy D. Tinsley 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death **Baltimore County** 5 Bonnie Jean Ct. Woodlawn 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. **Funeral** oreign Hours Days Director Country) Maryland 1 XM 2 F 49 Yrs 217-66-5727 08/09/1958 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 X No 28a-f show Gwynn Oak MD Baltimore death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 Bonnie Jean Court U.S.A. 21207 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces White etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Specify: Black f Yes, Give Year 1979-1980 3 Widowed Yes 2 X No specify: 4 Divorced ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If iten 27 is marked other than " injury or other traumatic event, the Medical E 21215-0036 Bank Associate Banking 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lorraine LaPrade Charles H. Tinsley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 1008 Witherspoon Road, Baltimore, Maryland 21212 Barbara A. Tinsley / Sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 02/22/2008 Owings Mills, Maryland Garrison Forest VA 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Hypertensive cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit executed Physician/Medical X UNPENDED attending physician for use as the burial -X AMERICA, perFh, 23a,27,perME,g879 5/8/08 TT certificate be Box 68760, IF FEMALE: 23d. Date of delivery 23c, if ves, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? Yes 2 1 🗸 Yes 2 No No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Division of Vital Be examiner? Hospital: 1 Inpatient 2 Other 4 Nursing Home 5 Residence 6 VOther: Scene ER/Outpatient 3 DOA 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Director: Pending 24 hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be 3 Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca within? 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 9, 2008 O.C.M.E. and

State 31. Date filed (Month, Day, Year), Registrar

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

111 Penn Street, Baltimore, MD 21201

2008

Chief Medical Examiner

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

David Fowler M.D.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                                     |  |                  | For State   | State of Maryland                       | Department of Health and N<br>Certificate of Death  |                                      | 6000                       | 04452  |
|-------------------------------------|--|------------------|---|---|---|--------------------------------------|----------------------------|--|
|                                     |  |                  | Registrar  1. Decedent's Name (First, Middle, La                              | st)                                     | oormoute or beam  | Reg. N                               | 10.                        | 3. Time of Death                                 |
|                                     | Physici  |                  | Robert  | S. TISON                                |   | Feb 12                               | ZUO8                       | 11:50 P.M  |
|                                     | /Medic<br>Examin   |                  | 4a. Facility Name (If not institution, giv                                    |   | 4b. City, Town, or Location of Death  |                                      | lc. County of Deal         | h  |
|                                     | Examin   | eı               | Two Hall  | enter                                   | Middle Riv  | er                                   | BALTI.                     | More -   |
|                                     | Funeral  |                  | 5. Social Security Number 6. S  | ex. 7. Age (In yrs. last                | birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.                              | 8. Date of Birth<br>(Month, Day, Yea | 9. Birt                    | hplace (State or Foreign                         |
|                                     | Director   |                  | 260-65-8777   | ×M 2□ F 87                              | Yrs. Months Days Hours  | Aug. 2, 19                           | 20 1001                    | The Co., GH                                      |
|                                     | p ,  | . {              | Usual Residence of Decedent 10a. State 10b. County                            | 10c City To                             | own or Location   |                                      |                            | 10d. Inside City Limits                          |
|                                     | aryla<br>ehov  | 5                |   |   | D 11:   |                                      |                            | 1 ☐ Yes 2 No                                     |
|                                     | he M   | ecto             | MD Balti  10e. Street and Number  | more                                    | 101. Zip Code   | 10a.                                 | Citizen of What Co         |  |
|                                     | a or   | 급                | Q817 1176:4-  | · No Ant 2                              | 21/ 21237   |                                      | 115                        | 4  |
|                                     | eath   | Funeral Director | 1012 COTTITION  | 12/Was Decedent Ever in U.S.            | 13. Was Decedent of Hispanic Origin? (Sp  | pecify Yes or No-                    | 14. Race - Ame             |  |
|                                     | fter d   | F                | 1 □ Never Married 2 Married   | Armed Forces?<br>1 1 Yes 2 □ No         | If Yes, specify Cuban, Mexican, Puerto  | Rican, etc.)                         | Black, Whit                | e, etc.  |
| 93                                  | el', o   | þ                | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates: 1943-44  | 1 ☐ Yes 2 M No Specify:   |                                      | Specify: U                 | )hite  |
| 21215-0036                          | within 72 hours after death with the Maryland<br>ene.<br>than "neturel", or Items 23e or 28e-f ehow<br>the Modical Examinet must be notified at  | Completed        | 15. Decedent's E<br>(Specify only highest gr                                  |   | 6a. Decedent's Usual Occupation (Give kind of work done during most of work                     |                                      | Kind of Business           | /Industry  |
| 2                                   | iffin<br>P. B.   | npi              | Elementary/Secondary (0-12)   | College (1-4or 5+)                      | life. DO NOT use retired)   | /                                    | 211                        | r.l.'n   |
| 2                                   | Hygier<br>Hygier<br>Sther ti   |                  | 17. Father's Name (First, Middle, Last  |   | Chaineer 18 Mother's Nam  | ne (First, Middle, Maid              | an Sumama)                 | TVICE  |
| anc                                 | ntel H<br>ed ot  | Be               | The Audition (Pilst, Middle, Last   | Villiam Tison                           |   | 1 Bon                                |                            |  |
| Maryland                            | should be filed within 72 hours after death with the Marylan nd Mentel Hygiene. I marked other then "neturel", or Items 23e or 28e-1 ehow umatic event, the Medical Examiner must be notified at   | ဥ                | 19a. Informant's Name/Relationship  |   | 9b. Mailing Address (Street and Number or Ru  | ral Route Number Cit                 | or Town, State,            | Zip Code)  |
| <u>8</u>                            | id 2 s<br>ith an<br>27 is<br>1 trau  |                  | Rotha Tison-  | wife                                    | 9812 Whitney DR. AG   | ot. 224. P                           | altimo                     | CO MN 21237                                      |
| စ်                                  | Heelth<br>tem 27<br>other tr   |                  | 20a. Method of Disposition  | 20b. Place                              |   |                                      | Location - City or         | Town, State                                      |
| e<br>E                              | Pages<br>nent of<br>int: if it<br>iry or o   |                  | 1 M Burial 2 ☐ Cremation 3 ☐<br>4 ☐ Donation 5 ☐ Other (Speci                 | JHemoval from State   A                 | sonville Natilem 2/1  | 5/08 An                              | der sonv                   | ille GA  |
| altimore,                           | permit. Pages 1 and 2 should<br>Department of Heelth and Men<br>Importent: if Item 27 is marke<br>eny injury or other treumatic<br>00.00.  |                  | 21. Signature of Funeral Service Lice   |   | 22. Name and Address of Facility  | rd Parkville                         |                            | 134  |
| m                                   | 99 = 9   |                  | Finisaly V. Sa  | Viotry                                  | Evans Funeral Chape   | - Cremati                            | on Service                 | es-Parkville                                     |
|                                     |  |                  | 23a. Part 1. Enter the disease, or comshock, or heart failure. List/only      | plications that caused the death. I     | Do not enter the mode of dying, such as cardiac   | or respiratory arrest,               |                            | Approximate<br>Intervat Between                  |
|                                     | Physician  |                  | Immediate Cause (Final disease or condition                                   | Demn                                    | Tie   |                                      |                            | Onset and Death                                  |
|                                     | /Medical   |                  | resulting in death)   | Due to (or as a consequen-              | ce of):   |                                      |                            |  |
|                                     | Examiner   |                  | Sequentially list conditions,   | p 1883                                  | serve beenne  |                                      |                            |  |
|                                     | B 11/ #  | Examiner         | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequen-              | ce of):   |                                      |                            |  |
|                                     | and and I-tran   | хап              | that initiated events resulting in death) Last                                | c. Due to (or as a consequent           | ce of):   |                                      |                            |  |
| 8760,                               | icate be executed physicien and street transit   |                  |   | · tun                                   | Alon Fin  |                                      |                            |  |
| 687                                 | ficate<br>physis the   | edical           |   | 0.                                      |   |                                      |                            |  |
|                                     | eeth certifi<br>ettending p<br>for use as  | Physician/Me     | IF FEMALE:<br>23b. Was decedent pregnant                                      | 23c. If yes, outcome of pregnancy       |   |                                      | 23d. Date of de            | livery   |
| Division of Vital Records, P.O. Box | deeth<br>e ette<br>ed for  | icia             | in the past 12 months?<br>1 ☐ Yes 2 ☐ No                                      | 1 Live birth 2 Fetel de                 |   |                                      | Month                      | Day Year   |
| Ö                                   | thet the de<br>led by the e<br>deteched f  | hys              | 9 Unknown   | 9□ Unknown                              |   |                                      |                            |  |
| S,                                  | res the<br>igned<br>be de  | by F             | Part II. Other significant conditions   | contributing to death but not resulting | ig in the underlying cause given in Part I.   |                                      | 0.                         | the cause of death?                              |
| ğ                                   | w require<br>been si   | ted              |   |   |   | 1 🗆 Yes                              | 2 No 3 □ P                 | robably 4 Unknown                                |
| မင့်<br>မင်                         | lawr<br>les be   | Completed        |   |   | 110.40  | 24a. Was an autopsy                  | prior to                   | utopsy findings available completion of cause of |
| <u>س</u>                            | The<br>page  | ပ္ပ              |   |   |   | performed<br>1 □ Yes 2               | ? death?<br>No 1 ☐ Yes     | 2 □ No   |
| /ita                                | clen   | Be               | 25. Was case referred to medical examiner?                                    | Hospital:                               | 0.00  | th (Check only one)                  |                            |  |
| 5                                   | Physical direction   | To T             | 1 ☐ Yes 2 No  27. Manner of Death   | 1 Inpatient 2 EN                        | Outpatient 3 DOA 4 Nursing H  | ome 5 Residence                      |                            | ocify)   |
| u<br>C                              | ding<br>h.<br>After<br>funer   | ion              | 1 Natural 5 ☐ Pending   | (Month, Day Year)                       | b. Time of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No   | 200. 00301100 1101/1                 | ijury cocorros             |  |
| S                                   | Attendideath.  | fica             | 3 Suicide 6 Could not b   | 28e. Place of Injury · At home          |   | 281. Location (Street                |                            | ural Route Number,                               |
| Š                                   | s efter<br>i Direct<br>d in by   | Certification:   | 4 Homicide  | building, etc. (Specify)                |   | City or Town, St                     | ate)                       |  |
|                                     | To the Hospital or Attending Physicien: The law requires that the deeth certificate be executed within 24 hours effer death.  To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit |                  | 29a. Certifier  (Check only 2 Medical Exa                                     | nysician: To the best of my knowle      | dge, death occurred at the time, date and place and/or investigation, in my opinion, death occu | , and due to the cause               | (s) and manner a           | s stated.  |
|                                     | he H<br>in 24<br>he Fi<br>plete  | Medical          | one)  | and manner stated.                      |   |                                      |                            |  |
|                                     | To T<br>To T<br>CO III   | Σ                | 29b. Signature and title of certifier   | Mi                                      | 29c. License number D 314 64  | 29d.                                 | Date signed (Mon.<br>2(14) |  |
|                                     | 1 61   |                  | P COVY  |   |   |                                      |                            |  |
|                                     | 671  |                  | 30. Name and address of person who  | completed cause of death (Item 23       | Ba) (Type, Print) FLITAN) ST funto 20   | 8 BALTIM                             | ose mu                     | 21201  |
|                                     | Sta  | to               | 31. Date filed (Month, Day, Year)   | 32. Registrar's Signature               | - 4   |                                      | 3 17                       | -, -01   |
|                                     | Registi  |                  | FEB 15  | 2008 Alexan A                           | Ba) (Type, Print) EUTAW ST SINTE 30   |                                      |                            |  |
|                                     | _  |                  |   |   |   |                                      |                            |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** February 13:30 M oridaet 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Johns Hoekins Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Days Hours Unknown 51 Director September 24,1956 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7966 Kavanagh Road death v 21222 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White ≥ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 11 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Farber Mary Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heidi Crispens Sister 7966 Kavanagh Road, Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State February 1 ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 15, 2008 4 ☐ Donation 5 ☐ Other (Specify) ature of Furieral Service License 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respirator Physician Failur hour disease or condition resulting in death) /Medical Due to (or as a consequence of): Examine Sepsis

Due to [or as a consequence of]: da Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examine that the death certificate be executed the burial-transit and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending pl IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ivision or Vital Records, ð Anemio 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe certificate 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 2 ☐ ER/Outpatient 3 DOA this 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospitat or Attending F within 24 hours after death.
To the Funeral Director: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res - 000 Feb, 15, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE, BACTIMOIZE, MD, 21224 ABOULNOUR 4940 EASTERN 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore stella Maris Timonium If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 F Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director Maryland 10g. Citizen of What Country? 10e. Street and Number or items 23a or 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, Pages 1 and 2 should be filed within 72 hours after 1 Tes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Health and Mental Hygiene. em 27 is marked other than College (1-4or 5+) Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Thomas 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 19a, Informant's Name/Relationship (Type, Print) ve Catonsville Important: If item 27 is any Injury or other tra once. 20b. Place of Disposition cemetery, crematory 20a. Method of Disposition ₽ 1 Dourial 2 □ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of d shock, or heart failure. List only one cause on the complete shock in the cause of the ca Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the a 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4X Unknown filled in by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has 1 Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 X No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending investigation 1 Yes 2 No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State FEB 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dire

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show

FEBRUARY 12, 2008 6:35 p.m.

Exami

Division or Vital Records, P.O. Box 68760, LOIS TERZANO

Baltimore, Maryland 21215-0036 Physic /Medi To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Re DHMH 17 Rev 1/2001

|   |            | For<br>State<br>Registrar  |   | State   | of Maryla  |  | artment of F<br>rtificate of  |                  |                              |   | iene<br>g. No.2 ()              | 0.8                       | 04455  |
|---|------------|--|---|---|--|--|---|------------------|------------------------------|---|---------------------------------|---------------------------|--|
| /siciar   | 1          | 1. Decedent's Nan  |   |   | rzano  |  |   |                  |                              | 2. Date of Deat<br>Februar                    | h                               | 200g                      | 3. Time of Death 6:35 p M                                |
| ledica<br>aminei  |            | 4a. Facility Name (  |   | n, give street and nu                                 |  |  | 4b. City, Town, c   |                  |                              | reprudi                                       | 4c. County                      |                           | · · · · · · · · · · · · · · · · · · ·                    |
| eral<br>ctor  |            | 5. Social Security I 212-36-3  | 103   | 6. Sex<br>1 □ M 2 🔀 F                                 | 7. Age (In yi                                    | rs. last birthday)<br>Yrs.                       | If Under 1 Year<br>Months Days  | If Unde<br>Hours | Min.                         | 8. Date of Birth<br>(Month, Day<br>0Ct 28     | , Year 938                      |                           | olace (State or Foreign<br>of Y Land                     |
| fied at   | וסו        | Usual Residence of 10a. State  | 10b. County                                   | ltimore   | 10c. (   | City, Town or Lo                                 | le River  |                  |                              |   |                                 | 1                         | 0d. Inside City Limits 1 ☐ Yes 2 \ No                    |
| ust be notified   |            | 10e. Street and Nu<br>1312 Ch  |   | ke Avenue   |  |  | 10f. Zip Code<br>21220  | )                |                              | 10  | Og. Citizen of V                |                           | ntry?  |
| any injury or other traumatic event, the Medical Examiner must be notified at once.  To Re Completed by Euneral Director                | 2          | 11. Marital Status<br>1  | 4 ☐ Divorced                                  | ried Armed F ried 1 □ Yes If Yes, G Year or 0         | 2 <b>∑</b> ]No<br>ive                            |  | Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes 2 No                  | Specify          |                              |   | Specify                         |                           | etc.<br>hite   |
| t, the Medical E  | nombiere   | (Spe   | cify only highe                               | nt's Education<br>est grade completed,<br>College     | (1-4or 5+)                                       | (Give  | dent's Usual Occup<br>kind of work done<br>DO NOT use retire<br>CTIOT DES | during mo        |                              | ng  | Interi                          |                           |  |
| To Re C   | 0          | 17. Father's Name  Evan  | (First, Middle,                               | Last)<br>Kalbad                                       | :h   |  |   | _                | ner's Name<br>I <b>na</b>    | (First, Middle, N                             |                                 | ne)<br>'OWSK:             | i  |
| er traumar  |            | 19a. Informant's N   |   | ship <i>(Type. Print)</i><br>no-husband               |  | 131  | ng Address (Street<br>2 Chesape   |                  |                              |   |                                 |                           | Code)<br>21220   |
| ijury or oth  |            | 4 ☐Donation  | ☐Cremation<br>5 ☐ Other (5                    |   | State D  | ulaney   |   |                  | 2/18                         | /08   | Coc. Location -                 | um, 1                     | •  |
| any n   |            | 21. Signature of F   | uneral Service                                | Licenso Willi   | am G.  | Dau 2  | 2. Name and Addre   |                  |                              | nard J.<br>Baltimo                            | Ruck,<br>ore, MD                | Inc.<br>212               | 214  |
| ian cal cal Examiner  | LVall      | Immediate Cause disease or condition resulting in death)  Sequentially list or if any, leading to in cause. Enter Undicause (Uisease or that initiated event resulting in death) | (Final on on on on on on on on on on on on on | b. Due to   | G CANCI (or as a consi                           | equence of):                                     |   |                  |                              |   |                                 |                           | Interval Between<br>Onset and Death                      |
| hvsician/Me   | yardianimo | IF FEMALE:<br>23b. Was deceder<br>in the past 12<br>1 ☐ Yes 2.<br>9 ☐ Unknowr  | 2 months?                                     |   | birth 2 ☐ Fe<br>nant at time o                   | etal death 3                                     | Ectopic pregnancy   | /                |                              |   |                                 | te of delive              | ery<br>Day Year  |
| ed by Ph  |            | Part II. Other sign  | ificant conditi                               | ons contributing to c                                 | leath but not re                                 | esulting in the u                                | nderlying cause giv   | en in Part       | I.                           |   |                                 | ribute to th              | ne cause of death?                                       |
| Completed   | )          |  |   |   |  |  |   | -                |                              | 24a. Was an<br>autopsy<br>perform<br>1□ Yes 2 | /<br>led?                       | prior to cor<br>death?    | psy findings available<br>mpletion of cause of<br>2 ☐ No |
| Compressy mired in by the toneral unector, page 2 should be retarded for use as Medical Certification: To Be Completed by Physician/Mer |            | 25. Was case refe examiner? 1 ☐ Yes 2 27. Manner of Dea 1  Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide   | No  | Hospital: 1  28a. Date (Mor                           | of Injury<br>oth, Day Year)                      | ER/Outpatier 28b. Time of Injury home, farm, str | 28c. Injur<br>Wor   | er:<br>4□N       | lursing Hom                  | 8d. Describe no                               | nce 6X10th w injury occurre     | red                       | HOSPICE  I Route Number,                                 |
| Medical C   |            | 29a. Certifier<br>(Check only<br>one)  | Certifying                                    | ng Physician: To the<br>Examiner: On the b<br>and mar | e best of my k<br>pasis of exami<br>nner stated. | nowledge, death<br>nation and/or in              | n occurred at the tir<br>vestigation, in my o                             | ne, date a       | and place, a<br>eath occurre | and due to the ca                             | use(s) and ma<br>ate and place, | anner as st<br>and due to | tated. the cause(s)                                      |
| M   |            | 29b. Signature and   | <u> </u>                                      | 2 -   |  |  | 29c. Licens   | e number         | 25                           | 29  | d. Date signe                   |                           |  |
| State   |            | DR. TAR 31. Date filed (Mor  | IQ MAHN                                       | 32.   | DULAN Begistrar's Sig                            | EY VALL  | EY RD.  | CIMON            | IUM,                         | MD 2109                                       | 3                               |                           |  |
| yistrar<br>v 1/2001   |            |  | FEB 1   | 5 2008  | alus.  | K A  |   |                  |                              |   |                                 |                           |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7 Per FH G8/6 2/15/08 JH.

State of Maryland / Department of Health and Mental Hygiene
FH G8/6 2/15/08 JH.

Reg. No.

Reg. No. Reg. No. 🚄 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Yea **Physician** 41 EBRUARY 2005 /Medical 4a. Facility Name (If not institution, give street and number) or Location of Death 4g. County of Death Examiner 3ALTI Cours SON MORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birinplace (State or Foreign Country) 6. Sex **Funeral** 1**Z**M 2□ F 249-22-768 92 NC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD 1 √Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 2303 Mosher USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify Black ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) lain-tenance Balto. 17. Father's Name (First, Middle, Last) (Unknown) 18. Mother's Name (First, Middle, Maiden Surname) (UNKINOW) Be 2 19a. Informant's Name/Relationship (Type. Print) Daughter
Was Infilliams Int Law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3D3 Mosher Balto Md. 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 2-18-08 Baltimore 4 □ Donation 5 □ Other (Specify) ay 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Vaughn C. Greene Funeral Services
5151 Balto Nat'l Pike Balto Md. Balto Md. ZIZZ9 Muche Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 0 **Physician** /Medical Due to (or as a consequence of) AILURE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy 1☐ Yes 2 No Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 NO 1 Impatient 2 ER/Outpatient 3 DOA Certification: To this funeral c 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t To the Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; /
completely filled in by the fi 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

FEB

BOX SECOURS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

5

2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year February 13:50 /Medical 10 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Sinai Hospital of Baltimore Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Days Hours 64 212-42-062 **Director** 10c. City, Town or Location 10a, State 10d. Inside City Limits at Baltimore Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f sh ither traumatic event, the Medical Examiner must be notified. 1 ☐ Yes 2 No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 years 17. Father's Name (First, Middle, Last) Be 10 Injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Thomas, Department of Health a Important: If item 27 is any Injury or other trau Chryster Ave. Baltimure 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 □Removal from State Woodlawn 21. Signature of Funeral Serv C Licensee 7286 Jacquetun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Ap oximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary em

Due to (or as a consequence of): **Physician** embolism 3 hours /Medical **Examiner** Metautatie lung 4 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi be exec Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the for use as IF FEMALE: if yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) P.O. 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 metaitares 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown brain Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy page certificate 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Manner of Death 1 ☑ Natural 28a. Date of Injury 28h Time of Certification: 28d. Describe how injury occurred After or Attending (Month, Day Year) 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

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State

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MD

2008

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Sinai Hospital of

2. Registrar's Signature

RES 000

Baltimore, 2401 West belvedere Ave.

February

10,2008

baltimore MD 21215

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                     |   |                | 1 - State Registrar  |  | artment of Health and M<br>rtificate of Death   |   | ene2 0 0 8                                      | 04458   |
|---------------------|---|----------------|--|--|---|---|---|---|
|                     | Physici   | an             | 1. Decedent's Name (First, Middle, Last)   |  |   | 2. Date of Death<br>Month                   | Day Year  | 3. Time of Death                                |
|                     | /Medic  |                | ARTHUR GORDON T  |  | <u> </u>  | February                                    | <b>11,</b> 2008                                 | 3:40 A <sup>M</sup>                             |
|                     | Examir  | ner            | 4a. Facility Name (If not institution, give street and n<br>BROADMEAD  | umber)   | 4b. City, Town, or Location of Death  |   | 4c. County of Death                             |   |
|                     | <b>-</b>  |                | 5. Social Security Number 6. Sex   | 7. Age (In yrs. last birthday)                           | Cockeysville  | 8. Date of Birth                            | Baltimore                                       | County  Place (State or Foreign                 |
|                     | Funeral<br>Director   |                | 578-22-0848 <sup>1∑M 2□F</sup>   | 86 Yrs.  | Months Days Hours Min.  | Jan 21,                                     | ear) Cour                                       | land  |
|                     | p ,   |                | Usual Residence of Decedent  |  |   | ,     |   |   |
|                     | show  | ō              | 10a. State 10b. County   | 10c. City, Town or Lo                                    |   |   | 1   | 0d. Inside City Limits 1 ☐ Yes 2 🕅 No           |
|                     | 28a-f   | Director       | Maryland Baltimore Coun  | ty Cock  | Keysville<br>  101. Zip Code  | 100   | . Citizen of What Cour                          |   |
|                     | 3a or   | Dir            | 13801 York Road  |  | 21030   | 109   | USA   | шуг   |
|                     | death   | Funeral        | 11. Marital Status 12. Was De Armod F  | cedent Ever in U.S. 13.                                  | Was Decedent of Hispanic Origin? (Sp<br>If Yes, specify Cuban, Mexican, Puerto          | ecify Yes or No-                            | 14. Race - Amend                                |   |
| 98                  | be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Evantime must be regilised at | y Fu           | 1 Never Married 2 Married 1 Never Married 1 Yes, G   | 2 No   | 1 □ Yes 2 ☒ No Specify:   | rican, etc.)                                | Black, White,                                   |   |
| Maryland 21215-0036 | 72 hours<br>"natural",  | ed by          | 3 ☐ Widowed 4 ☐ Divorced Year or  15. Decedent's Education   | Dates: 43- 43  |   | 140   | VVI   | nite  |
| 15                  | n "na   | Completed      | (Specify only highest grade completed  | (Give  | dent's Usual Occupation<br>kind of work done during most of work<br>DO NOT use retired) | ing   | b. Kind of Business/In-                         | dustry  |
| 212                 | filed withi<br>Hygiene.<br>other than   | mo             | Elementary/Secondary (0-12) College 5+   | (1-4or 5+) Life  | Insurance Agent   |   | Life Insur                                      | ance  |
| pu                  | be filed<br>tal Hygid<br>d other  | Be C           | 17. Father's Name (First, Middle, Last)  |  | 18. Mother's Name   | (First, Middle, Ma.                         |   |   |
| yla                 |   | 1º             | Arthur Gordon Turner,  |  | Floren  |   | Brainerd  |   |
| Mar                 | 12 sho<br>h and<br>7 is mu  |                | 19a. Informant's Name/Relationship (Type, Print) Lt. Cdr. Charles A.P. To  | (/   | ng Address (Street and Number or Rura   |   |   | Code)   |
|                     | s 1 and 2 should if Health and Mer item 27 is marke other traumatic   |                | 20a. Method of Disposition   | 20b. Place of Dispo                                      | C 476 Box 701, FPO  |   | c. Location - City or To                        | own State                                       |
| nou                 | Pages<br>nent of<br>int: If it  |                | 1 ☐ Burial 2 X Cremation 3 ☐ Removal from<br>4 ☐ Donation 5 ☐ Other (Specify)  | n State cernetery, crei                                  | natory or other place)  |   |   |   |
| Baltimore,          | - 문문 :  |                | 21. Sign fre of Fureral Service Licen  | Green Mot  | int Crematory 2/13  | /2008 Ba                                    | altimore, N                                     | Maryland  |
| m                   | Depa<br>Depa<br>Impo<br>any ii  | I              | Martin D. Lawson   | 6  | TTCHELL-WIEDEFELD<br>500 York Road, Ba  | FUNERAL<br>Itimore                          | HOME, INC.<br>Maryland 2                        | 1212  |
|                     |   |                | 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on  | caused the death. Do not ent                             |   |   |   | Approximate<br>Interval Between                 |
| B                   | Physician   |                | Immediate Cause (Final disease or condition  | INFWE  | NZA   |   |   | Onset and Death                                 |
|                     | /Medical<br>Examiner  |                | resulting in death)  Due to  | (or as a consequence of):                                | 1. <del>1 1 1</del>   |   |   |   |
|                     |   | e.             | Sequentially list conditions, if any, leading to immediate b. Due to   | o (or as a consequence of):                              |   |   |   |   |
|                     | d<br>ansit  | Examine        | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  |  |   |   |   |   |
| oʻ                  | an an   | Еха            |  | (or as a consequence of):                                |   |   |   |   |
| 8760,               | cate be executed<br>bhysician and<br>the burial-transit   | dical          | d  |  |   |   |   |   |
| 9                   |   | /Mec           | IF FEMALE:   | utomo of prognance                                       |   |   |   |   |
| Вох                 | death certifi<br>e attending I<br>id for use as   | Physician/Me   | in the past 12 months?   |  | Ectopic pregnancy Other (specify)   |   | 23d. Date of delive<br>Month                    | ory<br>Day Year                                 |
| 0                   | that the di<br>ed by the<br>detached  | nysic          | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown 9 ☐ Unk  |  | Other (specify)   |   |   |   |
| ٥,                  |   | by PI          | Part II. Other significant conditions contributing to  | death but not resulting in the u                         | nderlying cause given in Part I.  | 23e. Did tobac                              | cco use contribute to the                       | ne cause of death?                              |
| Records,            | w requires<br>been sign<br>should be  | ted            | multiple stro  | Kls  |   | 1 □ Yes                                     | 212No 3□Prob                                    | ably 4 Unknown                                  |
| ecc                 | aw<br>as t  | Completed      | Ischemic hear  | + discos   | <i>l</i>  | 24a. Was an autopsy                         | prior to cor                                    | psy findings available<br>appletion of cause of |
| <u>=</u>            | Th<br>ate<br>pag  | Con            | chronic Kldning  | d131051  |   | performed<br>1 ☐ Yes 2 🕏                    | d? death?<br>1No 1 ☐ Yes                        | 2□ No   |
| Vital               | Physician: Th<br>this certificate<br>ral director, pag  | Be             | 25. Was case referred to medical examiner?  Hospital:  |  | Othor   | Check on one                                |   |   |
| of                  | Phys<br>r this<br>ral di  | 1: To          | TE Tes ZEPNO   | Inpatient 2 ER/Outpatien of Injury 28b. Time of          | 1 3 DOA 4 P Nursing Ho  | me 5 Residenc<br>28d. Describe how          | e 6 ☐Other (Specify                             | y)  |
| lon                 | Attending I<br>ir death.<br>ector: After<br>by the funer  | atlor          | 1 ☑ Natural 5 ☐ Pending (Mo<br>2 ☐ Accident investigation  | a of Injury 28b. Time of<br>nth, Day Year) Injury        | 28c. Injury at<br>Work?<br>M 1 ☐ Yes 2 ☐ No   |   | injury occurred                                 |   |
| Division            | or Attendater death<br>Director:<br>in by the   | Certification: | 3 Suicide 6 Could not be   | e of Injury - At home, farm, str<br>ding, etc. (Specify) | eet, factory, office  | 28f. Location (Stree<br>City or Town, S     | et and Number or Rura                           | I Route Number,                                 |
| Ö                   | ital or A   | Cer            | , and the state of | anig, etc. ( <i>Specify</i> )                            |   | Chy of Town, S                              | oiate)  |   |
|                     | the Hospital or<br>nin 24 hours afte<br>the Funeral Dir<br>npletely filled in   | edical         | (Check only 2 Medical Examinar: On the   | basis of examination and/or inv                          | occurred at the time, date and place, a vestigation, in my opinion, death occurred      | and due to the caus<br>ed at the time, date | se(s) and manner as st<br>and place, and due to | ated. the cause(s)                              |
|                     | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer   | Med            | one) and main 29b. Signature and title of certifier  | nner stated.   | 29c. License number   |   | Date signed (Month,                             |   |
| }                   | F 3 F δ   |                | Baller C.  | will m   |   |   |   | **  |
| 21                  | 0   |                | 30. Name and address of person who completed cau   | ise of death (Item 2 a) (Type.                           | Print)  |   | 07.1100   | NO N  |
| 10                  |   |                | BARBARA CARROL   | L,M.D. 138   | OI YORK RD.   | COCKI                                       | 2/11/20<br>EYSVILLE                             | = MD  |
| :25                 | Sta   |                | 31. Date filed (Month, Day, Year) 432.   | Registrar's Signature                                    | 6)  |   | l   | 1.3   |
|                     | Registr   | ar             | FEB 15 ZUUS  | 1.3.0 88 85  |   |   |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25,27,29a per dr 0876 02/15/08dhb Reg. No. 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 12:10 PM 20,2008 /Medical 4a. Facility Name (If not institution, give street and number dica Examiner City, Town, or Location of Death unty of Death BALTIMORELUASHINATOR GIEN BURNIE INNE HRUNDE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 16, 1 Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 M 2 KF Hours 219-16-2653 90 Yrs Dec. Director 1917 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 📆 No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 10327 W. Furnace Branch Rd. 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify. þ 3 Widowed 4 □ Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 Is marked other? injury or other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Emory Lowry Charlotte Anna Mary Reed 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8377 Elm Road Millersville, MD 21108 Howard W. Thorn, III/Son 20b. Place of Disposition (Name of Commetery, crematory or other place)

Note the commeter of Method of Disposition Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 □Removal from State Donation 5 Other (Specify) 01-25-2008 Crownsville, MD proting of Formeral Con AGUNAME and Address of Facility Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne Md 21227 any 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CONGESSIJE ルトから /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or deriying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed certificate Division or Vital 2 40 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo မ 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 Natural in 24 hours after the Funeral Director; After Funeral Director; After funeral filled in by the funeral 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 20065703 Jan, 20, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

WASUNOTON

2008

32. egistrar's Signature

MOSIM

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|            |  |                  | 1 - For Amend Ite  | nn 27 State o                                 | ir., g876, 627  | Partment of I<br>ertificate of                    | Health and I<br>Death                      | Mental Hyg                               | iene                                | 8 04460                                   |
|------------|--|------------------|--|---|---|---|--|--|-------------------------------------|---|
| 12         |  |                  | 1. Decedent's Name (First, Midd  |   |   |   |  | 2. Date of Dea                           | th                                  | 3. Time of Death                          |
| 5.7        | Physic<br>/Medi  |                  | John F. Voith  |   |   |   |  | January                                  | Day 31, 20                          | 908 3:45 AM                               |
|            | Examir   |                  | 4a. Facility Name (If not institution  | on, give street and nur                       | nber)   | 4b. City, Town, o                                 | or Location of Death                       |  | 4c. County                          |   |
|            |  | Market State     | Montgomery Ge  |   |   | 01ney   |  |  | Montgo                              | omery                                     |
| #.<br>17   | Funeral  |                  | 5. Social Security Number  | 6. Sex<br>11☑ M 2☐ F                          | 7. Age (In yrs. last birthda                              | (y) If Under 1 Year<br>Months Days                | If Under 24 Hrs.<br>Hours Min.             | 8. Date of Birth<br>(Month, Day)         | Year)                               | Birthplace (State or Foreign Country)     |
| Conf.      | Director   |                  | 577-76-6571 Usuaf Residence of Decedent  | .A  | 84 Yrs.   |   |  | Jan 7,                                   | 1924                                | Washington DC                             |
|            | land<br>w  |                  | 10a. State 10b. Count  | у   | 10c. City, Town or  | Location  |  |  |                                     | 10d. Inside City Limits                   |
|            | Marylan<br>fahow<br>lied al  | Ö                | MD Mont  | gomery  | Gaithe  | rsburg  |  |  |                                     | 1 ☐ Yes 2√2 No                            |
|            | ith the M<br>or 28a-f  | rec              | 10e. Street and Number   | -   |   | 10f. Zip Code                                     |  | 1  | 0g. Citizen of W                    | Vhat Country?                             |
|            | th with  | Funeral Director | 1616 Hickory K   | Knoll Road                                    |   | 208   | 185  |  | USA                                 | Δ   |
|            | deat<br>ms 2   | ner              | 11. Marital Status   | 12. Was Dece                                  | edent Ever in U.S. 1                                      | 3. Was Decedent of H                              | Hispanic Origin? (Si                       | pecify Yes or No-                        | 14. Race                            | - American Indian,                        |
| 9          | within 72 hours after death with the Maryland<br>ane.<br>than "natural", or Items 23a or 28a-f ahow<br>na Madical Exeminer must be notified at | Ē                | 1 ☐ Never Married 2 ☐ Ma   |   | 2 No  | _   | an, Mexican, Puerti                        | o Hican, etc.)                           |                                     | k, White, etc.                            |
| 93         | ours<br>ral,   | d by             | 3 ☐ Widowed 4 💢 Divorce  | d If Yes, Giv                                 | ates: 142-46  | 1 ☐ Yes 2X No                                     | Specify:                                   |  | Specify                             | white                                     |
| 21215-0036 | 72 h<br>'natu  | Completed        | 15. Decede<br>(Specify only highe  | nt's Education<br>est grade completed)        | (Gi   | cedent's Usual Occup<br>ve kind of work done      | during most of wor.                        | kina                                     | 16b. Kind of Bu                     | siness/Industry                           |
| 121        | vithin<br>ne.<br>hen   | Id<br>Id         | Efementary/Secondary (0-12)  | College (1                                    | -4or 5+)  | . DO NOT use retire                               | d)   |  | heati                               | ng and                                    |
|            | filed v<br>Hygie<br>other t  |                  | 12 17. Father's Name (First, Middle  | 0   | sel   | f employe   |  |  |                                     | ditioning                                 |
| and        | 2 should be filed withir<br>and Mental Hygiene.<br>Is marked other than<br>sumatic event, the M.   | Be               | Ferdinand Jo   | •   |   |   |  | ne (First, Middle, I                     |                                     | θ)  |
| Ž          | should<br>nd Men<br>marke<br>umaric  | 10               |  |   | 401.14  |   |  | May Beck                                 |                                     |   |
| Maryland   | nd 2 sl<br>lith an<br>27 is r<br>r traur   |                  | 19a. Informant's Name/Relation Bernadette Pat                                      |   |   | ling Address (Street                              |  |  |                                     |   |
| d)         | 8 8 E E  |                  | 20a. Method of Disposition   | Lerson, dat                                   |   | 02 Shadown position (Name of                      | lage ler                                   |  |                                     | 20832<br>City or Town, State              |
| Baltimore, | ages<br>nt of<br>t; if it  |                  | 1 Burial 2 Cremation   |   | comptant o  | rematory or other place                           | ce)  |  | 200. Location -                     | City of Town, State                       |
| 뜶          | it. Pi   |                  | 4 ☑ Donation 5 ☐ Other (3  |   | 7   | 00.11   |  |  |                                     |   |
| Ba         | permit. Pages 1<br>Department of H<br>Important: If Ite<br>any Injury or ot<br>once.   |                  | 21. Sign Jure of Euneral Service   | S. Wade                                       |   | State Anat<br>Baltimore,                          | -  |  | Baltimo                             | ore Street                                |
|            |  |                  | 23a. Part . Enter the disease, o shock or heart failure. Lis                       | or complications that cat only one cause on e | aused the death. Do not a                                 | inter the mode of dyir                            | ng, such as cardiac                        | or respiratory arre                      | est,                                | Approximate<br>Interval Between           |
| 4          | Physician  |                  | Immediate Cause (Final disease or condition  | _   | TOS IN  |   |  |  |                                     | Onset and Death                           |
|            | /Medical   |                  | resulting in death)  | Due to (                                      | or as a consequence of):                                  |   |  |  |                                     |   |
|            | Examiner   |                  | Sequentially list conditions   | b   |   |   |  |  |                                     |   |
| 7          | ם ב  | ner              | Sequentially list conditions, if any, leading to immediate cause. Enter underlying | Due to (                                      | or as a consequence of):                                  |   |  |  |                                     |   |
|            | icate be executed<br>physician and<br>s the burial-transit   | Examin           | Cause (Disease or injury that initiated events resulting in death) Last            | c   |   |   |  |  |                                     |   |
| 00         | e exection a   | Ě                | resulting in death, cast   | Due to (                                      | or as a consequence of):                                  |   |  |  |                                     |   |
| 68760,     | ate b<br>hysic<br>the b  | dicai            |  | d.  |   |   |  |  |                                     |   |
| -          |  |                  | fF FEMALE:   | 1   |   |   |  |  |                                     |   |
| Вох        | leath certifications attending part of the use as  | Physician/M      | 23b. Was decedent pregnant in the past 12 months?                                  |   | come of pregnancy<br>inth 2 Fetal death 3                 | Ectopic pregnancy                                 | 1  |  |                                     | of delivery                               |
|            | at the dea   | SIC              | 1 Yes 2 No   | 4☐Pregn<br>9☐Unkno                            |   | Other (specify)                                   |  |  | Mon                                 | ith Day Year                              |
| P.0        | that thed by   | Phy              |  |   | and have an an arranged as the state of                   |   |  |  |                                     |   |
| ŝ          | es pe  | by               | Part II. Other significant conditi   | ons contributing to de                        | eath but not resulting in the                             | underlying cause giv                              |  |  |                                     | bute to the cause of death?               |
| O.C        | w requir<br>been s<br>should   | ted              | DECKO  | ) LSC   | MARVITA   | 1 1100  | LEINSD                                     | 1 Ye                                     | s 2 ⊡•No                            | 3 Probably 4 Unknown                      |
| Records,   | e law<br>has b   | Completed        | INSEASE,   | ATRIA   | L fibi  | illatu  | ON   | 24a. Was an                              | V . D                               | Vere autopsy findings available           |
| =          |  | Co               | DUSPHAG  | FIA   |   |   |  | perform                                  | ned? d                              | eath?                                     |
| Vital      | Physician: This certificated director, p   | Be               | 25. Was case referred to medical examiner?   |   | ,   |   |  | th (Check only one                       | 9)                                  |   |
| of         |  | P.               | 1 ☐ Yes 2 ☑ No   | 1   | npatient 2 ER/Outpati                                     |   | 4 🗆 Ivuising no                            | ome 5 Reside                             | nce 6 Othe                          | r (Specify)                               |
| n<br>0     |  | ő                | 27. Manner of Death  1 X Natural 5 □ Pendii  | 28a. Date of (Monti                           | of Injury 28b. Time<br>h, Day Year) Injury                | Wor   | y at<br>k?                                 | 28d. Describe ho                         | w injury occurre                    | bd  |
| Division   | Attending r death. sctor: After by the fune  | Certification;   | 2 Accident investi   | igation<br>not be                             |   |   | Yes 2 □No                                  |  |                                     |   |
| <u>≥</u>   | or Attency after death Director:   | Ħ                | 4 Homicide determ  | nined 286. Place                              | of Injury - At home, farm, s<br>ng, etc. <i>(Specify)</i> | street, factory, office                           |  | 28f. Location (Sti<br>City or Town       |                                     | or or Rural Route Number,                 |
|            | To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the                                      |                  | 00 0 1111  | 9   |   |   |  |  |                                     |   |
|            | To the Hospital within 24 hours a To the Funeral (completely filled  | edical           | 29a. Certifier (Check only one) Certifyii 2 Medical                                | examiner: On the ba                           | best of my knowledge, de-<br>sis of examination and/or    | ath occurred at the tin<br>investigation, in my o | ne, date and place,<br>pinion, death occur | and due to the ca<br>red at the time, da | iuse(s) and mar<br>ate and place, a | nner as stated.<br>nd due to the cause(s) |
|            | thin the mple  | Mec              | 29b. Signature and title officertifie  | and mann                                      | er stated.  | 29c. Licens                                       |  |  |                                     |   |
|            | viti<br>To To  |                  | XX/A   | $M \cdot N$                                   |   |   | 0650Z                                      |  | 12 11 0                             | (Month, Day, Year)                        |
| ,          | 7  |                  | TOUX   | , , ,   |   |   |  | - 7                                      | 121                                 | / 0 /                                     |
|            | I  |                  | 30. Name and address of person   | who completed cause UE GT                     | ^^ /\   |   |  | A /                                      |                                     | 1 2223                                    |
|            | Sta  |                  | 31. Date filed (Month, Day, Year,  | 1.49  | egistrar's Signature                                      | DI frinc  | e thillip                                  | 104.01                                   | neym                                | 0 20832                                   |
|            | Registr  |                  |  | 2008  | as the tops   | att.  |  |  |                                     |   |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State amend #18 Per FH G876 2/21/08 Cartificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 30 M lega 7 0 0 /Medical give street and number) Facility Name (If not institution. 4b. City, Town, or Location of Death 4c. County of Death Examiner Saltimore enversity Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign New York **Funeral** 6. Sex 7. Age (In vrs. last birthday Hours oct. 9, 1949 1 □ M 2 💢 F Days Min. 58 100-42-0079 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits r 28a-f sh notified MD Harford Joppa 1 Yes 2010 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 ral", or items 23a or Examiner must be 509 Cider Press Court Apt.M 21085 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2X Married Puerto altimore, Maryland 21215-0036 1 Yes 2□ No Specify: Completed by SpecifyHispanic 3 Widowed 4 Divorced "natural" Rican f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Clerical 12 17. Father's Name (First, Middle, Last) 18. DETTINA (Firs Middle Maiden Surname) Pages 1 and 2 should be file ment of Health and Mental Hi ant: If Item 27 is marked oth Be Quirindingo Antonio Lamboy Deltina ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 Cider Press Court Apt. M, Joppa,MD 21085 Robert Vega-spouse 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) ANS FUNERAL CHAPEL ID CREMATION BELAIT Department of Important; If It any Injury or o 1 ☐ Burial ★☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Feb. 17,2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3 Newport Drive Evans Funeral Chapel And Cremation Services tuda Forest Hill,MD 21050 endral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine X pue the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical as attending p use a IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. has been signed by the ge 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerformed 2/ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

Division or Vital Records. certificate ha funeral director. After this tal or Attend s after death. Il Director: /

Completed Be ို Certification:

Hospital

the

within 24 hours aff

To the Funeral D

completely filled in

Medical

Registrar

Lebron Ralph 31. Date filed (Month, Day, Year) 2008 FEB 15

29b. Signature and titte of certifier

2**2**No

5 Pending investigation

6 Could not be determined

1 ☐ Yes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

(Check only one)

1 Inpatient

(Month, Day Year)

28a. Date of Injury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Gre-32. Registrar's Signature

2 ER/Outpatient 3 DOA

М

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

29c. License number 952504573

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Street Greene.

Battimore,

26. Place of Death Check onl one

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day IAMS loth 08.18 AM February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner oper Chesapeake Medical Center 24 Hrs. . Age (In yrs. last birthday If Under Hours 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 ▼ F 241-38-008 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifiled at Edge WOOD 1 □Yes → No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21040 rbinger Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
title DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print Wiece) permit. Pages 1 and 2: Department of Health a Important; If Item 27 is any Injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other place) IrasL Edgewood, Hardinger Baltimore, Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licensee e Freneral Services mo136 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying the has cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Hemorrhagic Temporoponetol 82 hours 4 cute /Medicai Due to (or as a conse of nce of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-trat Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ▼ No Month Vear Day 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1∐ Yes Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of Certifier D0056607 February 10th mo 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n

Registrar

DHMH 17 Rev 1/2001

State

JOSEPH

31. Date filed (Month, Day, Year)

EEB

ANGELO,

15

2008

M-800-45.32

Dretha

Suit # 205 No 602

32 Registrar's Signature

S. ATWOOD Rd.

MD 21014

BELAJR

08-01236

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 04463

| nthony William W  |                | n State of Maryla<br>For State  | nd / Departifica<br>Certifica        | ate of Death                | and Montain                                  | Reg. N   | o                                      |                                |
|---|----------------|---|--------------------------------------|-----------------------------|--|--|--|--------------------------------|
| Dhysisian   | Re             | Decedent's Name (First, Middle,Last)  |                                      |                             |  | 2. Date of Death<br>Month Day                      | Year                                   | 3. Time of Death<br>1240 hrs   |
| Physician ** * Examine  | 4              | Anthony William   | Wilson_                              |                             |  | Month Day<br>February 12,                          | 2008<br>4c. County of Deat             |                                |
|   |                | . Facility Name (if not institution, give street and nur  |                                      |                             | , or Location of Deat                        | n  | Baltimore Co                           |                                |
|   |                | 4114 Taylor Avenue  |                                      | Nottingh                    |  | s 8 Date of Birth(M                                | M/DD/YYYY) 9. Bi                       | rthplace (State or             |
| Funeral   | 5              | Social Security Number 6. Sex   | 7. Age (In yrs. last birt            | thday) If Under 1<br>Months | Days Hours Mi                                | n.   | Forei                                  | gn<br>ountry) DC               |
| Director  |                | 213-82-1233 1XM 2 F   | 48                                   | Yrs.                        |  | Aug. 5,  | 1959 L                                 | 20                             |
|   | U              | sual Residence of Decedent  | 10c. City, Town                      | or Location                 |  |  |  | 10d. Inside City Limits        |
| any   | 1              | Da. State 10b. County   | Tioc. City, Town                     |                             |  |  |  | 1 X Yes 2 No                   |
| show  | 5 1            | Maryland N/A  |                                      | 10f. Zip Co                 | Baltimor <u>e</u>                            | City 10g.  | Citizen of What Co                     | untry?                         |
| Aaryls 1840   | Director       | 0e. Street and Number   |                                      |                             | 21224  |  | United St                              | -ates                          |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Mediral Examiner must be notified at once.   |                | 6618 O'Donnell Stre   |                                      | Tan Mara Danadonta          | of Hispanic Origin? (                        | Specify Yes or No-                                 | 14. Race - Ame                         | erican Indian, Black,          |
| death with the Maryland or items 23a or 28a-f show must be notified at once.  |                | 1. Marital Status 12. Was Dec Armed F   | cedent Ever in U.S.<br>orces?        | If Yes, specify C           | uban, Mexican, Puer                          | rto Rican, etc.)                                   | White, etc.                            |                                |
| death<br>or ite   | <u>.</u>       | T Yes   | 2X No                                | 1 Yes 2 X                   | No specify:                                  |  | Specify:                               | White                          |
| after   | <u>a</u>  -    | Widowed 4 X Divorced If Yes, Give Yes or Dates:  15. Decedent's Education (Specify only highest gra                                     |                                      | Decedents Heuri Oc          | cupation (Give kind o                        |  | b. Kind of Busines                     | s/Industry                     |
| hours<br>natu   |                |   | 1-4 or 5+)                           | during most of working      | g life. DO NOT use i                         | retired)   |  |                                |
| 36<br>n 72<br>n 72<br>han "   | Be             | G.E.D.  |                                      | Roofer                      |  |  |  | enance                         |
| with with her t   | Completed      | 17. Father's Name (First, Middle, Last)   |                                      |                             |  | me (First, Middle, Mai                             |  |                                |
| at the  | Bec            | William Stephen Wilso   | on                                   |                             | Je   | nnina Marl   | ene Bass:                              | 1.<br>ate Zin Code)            |
| 212<br>212<br>wild be<br>Ment<br>mark   | 라              | 19a. Informant's Name/Relationship (Type, Print )   |                                      | 19b. Mailing Address        | (Street and Number                           | or Rural Route Number                              | more Ma                                | ryland 2122                    |
| AD<br>2 sho<br>h and<br>27 is   |                | Ms. Jeanine Wilson (Si  | ster)                                | e of Disposition (Name      |  | Date Saiti   | 20c. Location - City                   | or Town, State                 |
| e, C. Land Healt item   | Ī              | 20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal  | from State crem                      | natory or other place)      | 1  |  |  |                                |
| nor<br>hages<br>ant of<br>nt: If  |                | 1 X Burial 2 Cremation 3 Removal 4 Donation 5 Other Specify:  | St.                                  | Stanislaus                  |  | /16/2008   |  | ore, Marylan                   |
| nit. Partme   | ŀ              |   |                                      | 22. Name and A<br>Duda-R    | ddress of Facility<br>Tuck Funer             | al Home of   | Dundalk                                | Inc.                           |
| Ba<br>Perr<br>Dep<br>Inju   | l              | Magen E. Ken  |                                      | 7922 W                      | ise Ave.                                     | Dundalk,   | <u>Mary land</u><br>t, shock, or heart | Approximate Interv             |
| ் Physician   | 4              | 21. Signatur of Funeral Service Leansee  23. Part I. Enter the disease or complications that failure. List only one cause on each line. | caused the death. Do                 | not enter the mode of       | dynig, sacir as card.                        | ,  |  | Between Onset ar<br>Death      |
| ledical   |                | Immediate Cause (Final disease a. COLULIOI  | EXCITY WILLIAM                       | trial and ver               | itricular di                                 | latation   |  |                                |
| _kaminer  |                | or condition resulting in death)  Due to (or as   | s a consequence of):                 |                             |  |  |  |                                |
|   | _              | Sequentially list conditions, if any, leading to immediate b. Due to (or as   | s a consequence of):                 |                             |  |  |  |                                |
|   | ine            | cause. Enter Underlying Cause   |                                      |                             |  |  |  |                                |
| , =   | Examiner       | (Disease or injury that initiated events resulting in death) Last   | s a consequence of):                 |                             |  |  |  |                                |
| to, to be executed ysician and burial - transit   |                | d   |                                      |                             |  |  |  |                                |
| 0,<br>e be exe<br>ysician<br>burial -   | edical         |   | PII,27,perMF                         | E,g877, 3/3/00              | <u> 3 TT</u>                                 |  | 23d. Date of de                        |                                |
| Box 68760, e death certificate be the attending physic ed for use as the bur  | ¥              |   | es, outcome of pregnar               | 2 Fetal death               | 3 Ectopic p                                  | regnancy   | Month                                  | Day Year                       |
| Box 6876C  The death certificate  The attending physele for use as the b  | /sician/M      | past 12 months?   | egnant at time of death              | h 5 Other (Spec             | cify)  |  |  |                                |
| 30X<br>death  | ysi            |   | nknown                               |                             | anua giyan in Part                           | 23e. Did to  | bacco use contribu                     | ite to the cause of death?     |
| or the  | , Phy          | Part II. Other significant conditions contributing  |                                      | ulting in the underlying    | cause given in rait                          |  |  | Probably 4 🗸 Unknow            |
| ires that the signed by t   | d by           | Chronic alcohol abus  | e                                    |                             |  | 24a. Was   | an 24b. We                             | ere autopsy findings avail     |
| ords, w requir  | lete           |   |                                      |                             |  | autop<br>perfo                                     | med? dea                               | or to completion of cause ath? |
| tal Recol   | Completed      |   |                                      |                             |  | 1 🗸 Yes  |  | Yes 2 No                       |
| R The   | ြိ             | 25. Was case referred to medical  |                                      |                             | 26.Place of Death (C                         |  | Residence 6                            | Other: Scene                   |
| Vital Recchysician: The lave this certificate hard director, page 2   | Be Be          | examiner?  1 ✓ Yes 2 No   |                                      |                             |  |  | how injury occurred                    |                                |
| ing Phy After th  | -              | 27 Manner of Death 28a. D   | Date of Injury<br>Month, Day,Year)   | 28b. Time of Injury         | 28c. Injury at Work?                         |  | now injury *****                       |                                |
| OD on ath.  | į              | 1 X Natural 5 Pending 2 Accident Investigation  | İ                                    |                             |  |  | Street and Number                      | or Rural Route Number,         |
| Division of Vital Records, tal or Attending Physician: The law requirers after death.  The three of After this certificate has been in the funeral director, page 2 should be in by the funeral director, page 2 should the three of the three | i i            | 2 Accident Investigation 28e.   | Place of Injury - At hor             | me, farm, street, factor    | y, office building, etc                      | or Town,   | State)                                 |                                |
| DIVI  Ours after neral Dir  | Certification: | 4 Homicide determined (Spe  | ecify)                               |                             |  | and the to the cou                                 | se(s) and manner                       | as stated.                     |
| D<br>Hospital<br>24 hours<br>Funeral  |                |   | e best of my knowledge               | e, death occurred at the    | e time, date and place or opinion, death occ | ce, and due to the cau<br>curred at the time, date | and place, and du                      | ie to the cause(s)             |
| Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy comminetely filled in by the fineral director, page 2 should be detached for use as the b   | Modical        | and man   | asis of examination an<br>ner stated |                             | c. License number                            |  | 29d. Date signe                        | d (Month, Day, Year)           |
| F B F S   | ۶   ۶          | 29b. Signature and title of certifier   | Ton M                                | 25                          | O.C.M.E.                                     |  | February 13                            |                                |
|   | 1              | Mhun Grassell   | 1/11/2                               |                             | U.U.IVI.L.                                   |  |  |                                |
| $\alpha$  |                | 30. Name and address of person who completed  | cause of death (Item                 | 23a)<br>per 111 Penn 9      | treet, Baltimore                             | e, MD 21201  |  |                                |
| X   |                |   | Medical Examin                       |                             | acou, Daminor                                |  |  |                                |
|   | Stat           | e 31. Date filed (Month, Day, Year)   | 32. Registrar's Signatu              | the said                    |  |  |  |                                |

ORIGINAL

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrer Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Dorothy Mildred Walton **Physician** 9:50P M February 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Co. Rossville Franklin Woods Nursing Home Date of Birth (Month, Day, Year) Aug. 31,1917 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 ☐ M 2 ☐XF Yrs. Aug. Director 90 215-12-0258 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Item 27 is marked other than "netural", or Items 23a or 28e-f show other treumatic event, the Madical Examinar must be notified at 1 Yes 2X No Director Perry Hall Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21234 United States 3509 Fondulac Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 and 2 should be filed within 72 hours after w Health and Mental Hygiene. em 27 is marked other than "netural", or Itel 1 ☐ Yes 2√3 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 Total Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: ۵ White 3€3Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 11 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nettie Shifflett Linwood Shifflett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health at Importent: If Item 27 is any injury or other treat QDCE. 21234 3509 Fondulac Road Perry Hall, MD Mrs. Gloria J. Davies (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removarifrom State Baltimore, Maryland 2/13/2008 Gardens of Faith Cem. 4 Donation 5 Other (Specify) Fune al Service Acens 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature Dundalk, Maryland 21222 7922 Wise Ave. Rani. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 20 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Iclan/Medical as the t IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year jo in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 1 Yes 2 4 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe 1 Yes 2 -NO after death. | Director: After this certification of the funeral director. To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 D NO P 1 Yes 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide within 24 hours a To the Funerel ( 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

Tom Edmond Son 31. Date filed (Month, Day, Year)

monstore 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Franklin 32 Registrar's Signature

on

DHMH 17 Rev 1/2001

Square

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Pecedent's Name (First, Middle, Last) 2. Date of Death Day Physician Year 2008 好成 RAPURE /Medical 4a. Facility Name (If not institution, Town, or Location of Death c. County of Death Examiner Andalla MARCH Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday) **Funeral** 2□ F Yrs. Director 10a. State 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes 2 No Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Shoreman permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other trainmant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ဂ 19a. Informant's Name/Relationship (Type. Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 3816 Rd. Randallstum, MDZIU3 lorma Br20a. Method of Disposition 20b. Place of Disposition (Nai Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State altimure, M 21. Signature of Funeral Service Licensee 23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as call lac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NE **Physician** ADELE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death the 9□Unknown 9 Unknown þ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown ACE CIRCUR 2□ No 3 ☐ Probably 1 Tes , page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed? /es 214 No 1 Yes Division or Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**\**No 2 1 🗌 Yes 1 popatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation within 24 hours arren control to the Funeral Director; Aff 1 Tyes 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar JEVER

31. Date filed (Month, Day,

ou) m

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vol

32. Registrar's Signature

| 08-01060      |  |  |  |  |  |  |  |
|---------------|--|--|--|--|--|--|--|
| Demetry White |  |  |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Demetry White  |             | State of Maryland / Department of Health and Mer  For State  Certificate of Death  | ntal Hygien         |                      | 20                             | 08 0666                                   |
|--|-------------|--|---------------------|----------------------|--------------------------------|---|
| Physician  | / 1         | egistrar Decedent's Name (First, Middle, Last)   | 2. Date             | of Death             | No. Year                       | 3. Time of Death                          |
| Medical Examine  | _           | a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location   | Febr                | uary 6,              | 2008<br>4c. County of Death    | 0834 hrs                                  |
| (  |             | Baltimore Washington Medical Center Glen Burnie  | or Death            |                      | Anne Arundel                   |   |
| Funeral  | 5           | Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Months Days Hour   |                     | te of Birth (        |                                | thplace (State or Foreign<br>untry)       |
| Director   | 1           | (20-19-4296 1XM 2 F Yrs. 2 15  | NIIII.              | -18                  | -2007 N                        | aryland                                   |
| any  | _           | Isual Residence of Decedent  0a. State 10b. County 10c. City, Town or Location   |                     |                      |                                | 10d. Inside City Limits                   |
| Maryland<br>28a-f show<br>d at once.   | <u>.</u>    | MD Odenton   |                     |                      |                                | 1 Yes 2 Yo                                |
| the Marylam a or 28a-f st fified at one  | 2 1         | 6e. Street and Number  10f. Zip Code  2/11/3   | 2                   | 10g.                 | . Citizen of What Cou          | ntry?                                     |
| ath with the I items 23a or ist be notified  |             | Marital Status     12 Was Decedent Ever in U.S.     13. Was Decedent of Hispanic Ori   | igin? ( Specify Ye  |                      |                                | ican Indian, Black,                       |
| er death with the rough to must be not   |             | 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican Yes 2 No  |                     | etc.)                | White, etc.                    | 11  |
| 21215-0036 1d be filed within 72 hours after death with the Maryland dental Hygene. marked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.   | <u>`</u>    | 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give   |                     | e <b>I</b> 10        | Specify: 5                     | Industry                                  |
| 5-0036 ed within 72 hour lygiene. the Medical Exam   |             | Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT  |                     |                      | T T                            | _ ,                                       |
| 5-0036 led within 7 Hygiene. other than the Medica   |             | Z-Eather's Name (First, Middle, Last)  | er's Name (First, N | diddle Mai           | Ln+                            | ant                                       |
| 21215-Culd be filed v Mental Hygi marked oth c event, the  |             | Vicentia White   | FFRA                | 11.                  | Smith                          |   |
| s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Ro Completed by Firneral Director  | 2 1         | a Informant's ame/Relationship (Type, Print ) 19b. Mailing Address (Street and Nu  | mber or Rural Ro    | ut a umbe            | er, City or Town, State        | e, Zip <b>2</b> 0) / [3                   |
| more, MD 21215-00; Pages 1 and 2 should be filed with ent of Feath and Mental Hygien uit. If item 27 is marked other r other traumatic event, the Ma   | 1           | 0a. Method of Disposition (Name of Cemeter),   | 7                   | <u>او را</u>         | 20c. Location - City or        | Town, State                               |
| altimore,<br>mit. Pages 1 a<br>partment of He<br>portant: If ite<br>ury or other ti  |             | Surial 2 Cremation 3 Removal from State crematory or other place)  4 Donation 5 Other Specify:   | 1/2/1:              | 2/20                 | Ralto                          | MI  |
| Baltin<br>Permit. J<br>Departm<br>Importa  | 2           | 1. Signature of Funeral Service Licensee 2. Hame and Address of Facilities   | reene               | 15                   | 1000                           | Senzices                                  |
| Physician  | 12          | 3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as   | Ic. Pol             | tory arrest          | shock, or heart                | pproximate Interval                       |
| /Medical   | l.          | failure. List only one cause on each line.  mmediate Cause (Final disease a. Sudden Unexplained Reath in Infancy   |                     | •                    |                                | Between Onset and<br>Death                |
| taminer  |             | r condition resulting in death)  Due to (or as a consequence of):  |                     |                      |                                |   |
| Der  |             | Sequentially list conditions, any, leading to immediate Due to (or as a consequence of):   |                     |                      |                                |   |
| ed nsit  |             | ause. Enter underlying Gause Disease or injury that initiated c. Due to (or as a consequence of):  |                     |                      |                                |   |
|  |             | d  |                     |                      |                                | ļ   |
| o, o o, o, o, o, o, o, o, o, o, o, o, o,   |             | XX UNPENDED XX AMENDED 1,23a,27,28a-f per ME g878 4/4/08   | 8 amh               |                      | 22d Date of deliver            |   |
| Sox 6876( leath certificate e attending phy for use as the b   | 23          | past 12 months?  | ic pregnancy        |                      | 23d. Date of deliver<br>Month  | y<br>Day Year                             |
| . Box 6876 the death certificate by the attending phy ched for use as the l Physician/M.   | 325         | Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)   |                     | - "                  |                                |   |
| P.O. I so that the gned by the e detachee  |             | art II. Other significant conditions contributing to death but not resulting in the underlying cause given in P  |                     |                      | acco use contribute to         |   |
| List, P. P. Aquires to qualid be defended by the defended by t | ב<br>ב      |  |                     | Yes<br>a. Was an     |                                | bably 4 Unknown utopsy findings available |
| Records, I The law requires fifcate has been significate to a should be completed.   |             |  |                     | autopsy<br>performe  | prior to death?                | completion of cause of                    |
| Vital Recysician: The his certificate director, page   |             | 5. Was case referred to medical 26.Place of Death  | Line                | Yes 2                | No1 ✓ Y                        | es 2 No                                   |
| Division of Vital tal or Attending Physician. Its after death.  al Director: After this certical in by the funeral director and the funeral director.  | 2           | examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other,  | Nursing Home        |                      | esidence 6 🗸 Othe              | r: Scene                                  |
| n of 'n of 'h ding Ph. h. : After t  | <u>:</u>  2 | 7. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Wor (Month, Day, Year) 28b. Time of Injury 28c. Injury at Wor 1 Yes 2  | _ !                 | escribe hov          | w injury occurred              |   |
| /isior<br>r Attenc<br>ter death<br>irector:<br>n by the  | <u> </u>    | 2 Accident Investigation 2/8e. Place of Injury - At home, farm, street, factory, office building e   | Unk<br>etc. 28f. Lo |                      |                                | ural Route Number, City                   |
| Division or spital or death.  Division or spital or death.  Beral Director: After filled in by the fune.  Certification.   |             | Homicide determined (Specify) NESIGENCE  |                     | Town, Stat<br>Cadber | <sup>te)</sup><br>ry Rd, Odent | on, MD                                    |
|  |             | 9a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and plane)  2 ✔ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death o |                     |                      |                                |   |
| To the He within 24 To the Fe completed  | 2           | and manner stated.  9b. Signature and title of certifier  29c. License number  |                     |                      | 29d. Date signed (Mo           |   |
| ( )  |             | Mhine Grassell MD O.C.M.E.   |                     | 1                    | February 7, 200                | 8   |
| Dolphy   | 3           | O. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimor   | re MD 21201         | <b>.</b>             |                                |   |
| State  | e 3         | 1 Date filed (Martin Day Very) 22 Prejetren's Signature  |                     |                      | · -                            | · · · · · ·                               |
| Registra   |             | 1. Date filed (World, Day, Year)  52. Registral's Signature  |                     |                      |                                |   |

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Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. F gistrar's Signatur

29c. License number

88 13 Waltham Words Road.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** February 13, 2008 Mary Magdaline Waitkus 1:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 421 Barksdale Road Harford Joppa 5. Social Security Number tf Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Apr. 18, 1922 North Carolina 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 X F Vrs Director 85 241-18-5375 Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itsms 23s or 28e-f show the Medical Exempler must be notified at 1 ☐ Yes 2 X No Maryland Harford Abingdon Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after deeth wi and Mental Hygiene. Is marked other then "natural", or ttsms 23a 21009 502 Ramblewood Drive USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 N Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementary/Secondary (0-12) Coltege (1-4or 5+) 10 Shipping Clerk Chemical Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Miles Vernon Mize Dora (nmn) Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ges 1 and 2 it of Health i John S. Waitkus / Son 429 Breslin Road, Joppa, MD 21085 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: If ite any Injury or otl 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns 2-18-08 Baltimore, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Fineral Service Licenses 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician र् CATCING MA 5 months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetat death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ned by the a e detached for 1 ☐ Yes 2 No o 9 Unknown 9 Unknown <u>م</u> signed I Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š been si Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate 1 Yes 2 No of Vital : After this certification and funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospitat: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) ٩ 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Hospital or Attanding 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funerel Direct 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Lee Financin MD D39763 February 13, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2012 Tollgate Rd, Ste 102, Bel Air, MD 21015 Lee TANNERBHUM, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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2008

|                            |  |                  | 1 - For<br>Stata<br>Registrar   | State of                                    | Marylan                              | id / Depa<br><i>Cei</i> | artment<br>rtificate      | t of H                | ealth a<br>D <i>eath</i> | and M                                   |   |   | 008                         | 044                                     | 69                 |
|----------------------------|--|------------------|---|---|--------------------------------------|-------------------------|---------------------------|-----------------------|--------------------------|---|---|---|-----------------------------|---|--------------------|
| П                          | Physici  | an               | Decedent's Name (First, Middle,   |   |                                      |                         |                           |                       |                          |   | 2. Date of Dea<br>Month   | ath<br>Day  | Year                        |   |                    |
|                            | /Medic   |                  | Anna  | C.  |                                      |                         | imme                      |                       |                          |   | Februar   | -   |                             | 12:12                                   | $\mathbf{P}_{M}$   |
|                            | Examin   | er               | 4a. Facility Name (If not institution, 7606 Maple Road  | give street and num.                        | ber)                                 |                         |                           | ndal                  | Location o               | of Death                                | Month   Pay   Year   12,2008   12:12     Heath   4c. County of Death   Baltimore     Hrs.   8. Date of Birth   (Month, Day, Year)   March   20,1917   Maryland     March   20,1917   Maryland     10g. Citizen of What Country?   U.S.A.     (Specify Yes or Nower of Rican, etc.)   14. Race - American Indian, Black, White, etc.   Specify: White     Working   16b. Kind of Business/Industry   Own Home     Name (First, Middle, Maiden Sumame)   Newmeier     Rural Route Number, City or Town, State, Zip Code     Doppa, Maryland   21085     Drundalk, Maryland     Home of Dundalk, P.A.     Lint Road, Dundalk, MD.   21222     diac or respiratory arrest,   Interval Between Onset and Deat     Lint Road, Dundalk, MD.   21222     diac or respiratory arrest,   Interval Between Onset and Deat     Lint Road   20, 1917   1917   1917     23d. Date of delivery   Month   Day   Year     23d. Date of delivery   Year |   |                             |   |                    |
|                            | Funeral  |                  |   | 3. Sex 7                                    | . Age (In yrs.                       | last birthday)          | If Under                  | 1 Year                | If Under 2               |   | 8. Date of Birt   | Reg. No.  of Death Day Year ruary 12,2008  4c. County of Death Baltimore  of Birth Baltimore  of Birth Baltimore  10d. Inside City Limits 1 | Foreign                     |   |                    |
|                            | Director   |                  | 227-34-2466   | 1□M 2XF                                     |                                      | 90 Yrs.                 | Months                    | Days                  | Hours                    | Min.                                    | March March   | žo, 191   | 17 Mai                      | ryland                                  |                    |
|                            | D .  |                  | Usual Residence of Decedent  10a. State 10b. County   |   | 10c Cit                              | v. Town or Lo           | cation                    |                       |                          |   |   |   |                             | 10d Inside City                         | Limite             |
|                            | Aaryla<br>f sho  | ō                | Maryland Baltin   | nore  | 100.01                               | Dunda                   |                           |                       |                          |   |   |   |                             |   |                    |
|                            | the A  | rect             | 10e. Street and Number  |   |                                      |                         | 10f. Zip                  | Code                  |                          |   |   | 10g. Citizer  | of What Cor                 | untry?                                  |                    |
|                            | h with   | Funeral Director | 7606 Maple Road   |   |                                      |                         |                           | 2122                  | 22                       |   |   | U.  | S.A.                        |   |                    |
|                            | ams S  | ner              | 11. Marital Status  | 12. Was Deced                               | lent Ever in U                       | .S. 13.                 | Was Deced                 | ent of Hi             | spanic Orig              | gin? (Spe                               | ecify Yes or No-<br>Rican, etc.)  | - 14.   |                             |   |                    |
| 36                         | s after, or It   | by Fu            | 1 Never Married 2 Marrie  | d 1 Tyes 2                                  | 2∭ No                                | 1                       | 1 ☐ Yes 2                 |                       | Specify:                 |   | ,   |   |                             |   |                    |
| Ö                          | 72 hours after death with the Maryland<br>natural', or Itams 23a or 28a-f show<br>Jical Examiner must be notified at   | ed ba            | 3 X Widowed 4 ☐ Divorced  15. Decedent's  | Year or Date                                | es:                                  | 16a. Dece               | nent's Usua               | l Occupa              | ition                    |   |   |   |                             |   |                    |
| 75                         | n na   | Completed        | (Specify only highest<br>Elementary/Secondary (0-12)  | grade completed)  College (1                | 1or 6+)                              | (Give                   | kind of wor<br>DO NOT us  | k done d<br>e retired | luring most<br>)         | t of worki                              | ng  | 700. 11.114   | 5, 540                      | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                    |
| 212                        | ad with<br>giene<br>er tha   | Com              | 8 years   | College (1-                                 | +01 3+)                              | Hou                     | sewif                     | e                     |                          |   |   | Own I   | Home                        |   |                    |
| nd                         | be file<br>tal Hy<br>d oth   | Be               | 17. Father's Name (First, Middle, L.  | ast)  |                                      |                         |                           |                       |                          |   |   |   | mame)                       |   |                    |
| yla                        | d Men<br>narke<br>natic  | <sup>2</sup>     | Ludwig Lackl  | - (Time Ories)                              |                                      | 405 Maille              |                           | (04===4               |                          |   |   |   |                             | in Contail                              |                    |
| Maryland 21215-0036        | id 2 st<br>th and<br>th and<br>27 ia n<br>traun  | 18               | 19a. Informant's Name/Relationshi Linda Starner   | <sub>p (1998, Print)</sub><br>nie           | ece                                  |                         | -                         |                       |                          |   |   |   |                             | ip Code)                                |                    |
| <u>6</u>                   | s 1 an<br>f Heal<br>itam 2<br>other  |                  | 20a. Method of Disposition  |   | 20b. F                               | Place of Dispo          | sition (Nam               | ne of                 |                          |   |   |   | ion - City or 1             | Town, State                             |                    |
| e<br>E                     | Page:<br>nent o<br>int: if   |                  | 1 ☐ Mourial 2 ☐ Cremation : 1 ☐ Donation 5 ☐ Other (Spe   |   | sac Sac                              | red Hear                | t of J                    | esus                  | Cem.                     | 15,2                                    | 8008  | Dunda   | ılk,Mar                     | yland                                   |                    |
| Baltimore,                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic evant, the Medical Examination at the notified at once. |                  | 21. Signature of Funeral Service Li   | censee                                      | 01                                   | 1) 22                   | onne i                    | d Addres              | uner                     | ăl H                                    | ome of  | Dunda.  | lk,P.A                      | •                                       |                    |
| <u> </u>                   | 207299   |                  | Controlly   | (on)  | neli                                 |                         |                           |                       |                          |   |   |   | lk,MD.                      |   |                    |
|                            | 00000  |                  | shock, or heart failure. Listio   | omplications that ca<br>nly one cause on ea | ch line.                             |                         |                           | of dying              |                          |   | 1.  |   |                             | Interval Between                        |                    |
|                            | Physician -<br>/Medical  |                  | Immediate Cause (Final disease or condition resulting in death)   | a   |                                      | anc                     | a                         |                       |                          | noi                                     | J101.   |   |                             | un. Kn                                  | Jun                |
| ı                          | Examiner   |                  |   | Due to (o                                   | r as a conseq                        | uence of):              |                           |                       |                          |   |   |   |                             |   |                    |
|                            |  | Jer              | Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury | b. Due to (o                                | r as a conseq                        | uence of):              |                           |                       |                          |   |   |   |                             |   |                    |
|                            | cuted<br>nd<br>ransit  | Examine          | that initiated events   | c   |                                      |                         |                           |                       |                          |   |   |   |                             |   |                    |
| ò,                         | cate be executed<br>physician and<br>the burial-transit  |                  | resulting in death) Last  | Due to (o                                   | r as a conseq                        | uence of):              |                           |                       |                          |   |   |   |                             |   |                    |
| 8760,                      | death certificate be executed<br>e attending physician and<br>ad for use as the burial-transi  | edical           | `   | d   |                                      |                         |                           |                       |                          |   |   |   |                             |   |                    |
| 9 X                        | eath certific<br>attending p<br>for use as   | /Me              | IF FEMALE:  | 23c. If yes, outc                           | ome of pregna                        | ancy                    |                           |                       |                          |   |   | 23d   | Date of deli                | verv                                    |                    |
| Вох                        | death cer<br>a attendir<br>d for use   | clar             | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No  | 1 ☐ Live bir<br>4 ☐ Pregna                  | th 2 ☐ Feta<br>ntattime of d         | Ideath 3                | Ectopic pre<br>Other (spe |                       |                          |   |   | 200   |                             | ,                                       | ar                 |
| P.O.                       | that the de<br>ed by the<br>detached   | Physician/M      | 9 Unknown   | 9⊡ Unknov                                   | vn                                   |                         |                           |                       |                          |   |   |   |                             |   |                    |
|                            | law requires that the<br>as been signed by th<br>2 should be detache   | by P             | Part II. Other significant condition  | s contributing to dea                       | th but not res                       | ulting in the u         |                           | use give              |                          |   |   |   |                             |   |                    |
| ord                        | requir<br>een si<br>nould  | ted              | _ CW GM L   | 1/6470                                      | 1                                    | 1                       |                           | />                    | $\frac{-\nu}{\cdot}$     |   | 1 U Y   | res 2∐N   | 10 3 □ Pro                  | bably 4                                 | known              |
| Sec                        | elaw<br>hasb<br>ge2st  | Completed        | _ CAD,  | Mus   | <del>2</del>                         | filer                   | ~W~                       | na                    |                          |   | autop   | sy  | prior to c                  | opsy findings av<br>ompletion of cau    | railable<br>use of |
| a                          | iician: The<br>certificate hi<br>rector, page  |                  | 05.14   |   |                                      |                         |                           |                       |                          |   | 1 ☐ Yes   | 2 1 No  | 1 🗆 Yes                     | 2 <b>0</b> No                           |                    |
| ₹                          | Phyaician:<br>r this certific<br>ral director,   | o Be             | 25. Was case referred to medical examiner?  1 ☐ Yes = 2 ☑ 100   | Hospital:                                   | patient 2 🗆                          | ER/Outpatien            | it 3□ DO                  | Δ Othe                |                          | 100000000000000000000000000000000000000 |   |   | Other (Spec                 | i6a)                                    |                    |
| 10                         | g Phy<br>er this<br>eral d   | n: To            | 27. Manner of Death   | 28a. Date of<br>(Month                      | -                                    | 28b. Time of            |                           | Bc. Injury<br>Work    | 4 🗀 11401                |   |   |   |                             | ay)                                     |                    |
| ion                        | Attending For death.  actor: After by the funer.   | atlo             | 1 Natural 5 Pending 2 Accident investiga  | ition                                       | , Day (Gai)                          | injury                  | М                         |                       | r<br>∕es 2 🗆 N           | No                                      |   |   |                             |   |                    |
| Division of Vital Records, | t or Attendate death Diractor:   | Certification:   | 3 ☐ Suicide 6 ☐ Could no<br>4 ☐ Homicide determin   | 286. Place                                  | of Injury - At he<br>g, etc. (Specif | ome, farm, str          | eet, factory,             | , office              |                          |   | 28f. Location (S<br>City or Tow   | Street and N<br>vn, State)  | umber or Rui                | ral Route Numbe                         | ∍ <i>r</i> ,       |
| Ω                          | pitat o  |                  | 200 Continue 1 Continue   | Dhysician To the                            | and of musican                       | uuladaa daad            |                           |                       |                          | d =lana                                 |   |   |                             |   |                    |
|                            | To the Hospitat or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page  | edical           | 29a. Certifier 1 ☐ Certifying (Check only one)  1 ☐ Certifying 2 ☐ Medical E                                | xaminer: On the bas<br>and manne            | is of examina                        | tion and/or in          | vestigation,              | in my op              | inion, deat              | th occurr                               | ed at the time,   | date and pla  | a manner as<br>ace, and due | to the cause(s)                         |                    |
|                            | To the Hospitat within 24 hours a To the Funeral c completely filled   | Me               | 29b. Signature and title of certifier   | A-2   |                                      |                         | 29c.                      | License               | number                   | 7 (                                     | 7,  | 29d. Date si  | igned (Month                | , Day, Year)                            | ^                  |
| }                          | 7  |                  | ) /VIS  | TN · U· NT                                  |                                      |                         | لـ ا                      | ノ <del>ー</del> `      | 28                       | <b>/-&gt;</b>                           | 4   | 02-   | 13-                         | 2008                                    | 54                 |
| 5                          | γ  |                  | 30. Name and address of person w  | ASEEN                                       | 1, 5                                 | to9.                    | Print)                    | <del>\$</del> T       | BR                       | N                                       | BLV   | D,  | MD                          | -2/2                                    | -2/                |
|                            | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year)<br>FEB 1 5 20   | 08 32. Re                                   | gistrar's Signa                      | iture                   | K.                        |                       |                          |   |   |   |                             |   |                    |

|   |                 | For State Registrar   | State   | of Ma                   | aryland       |                               | artmen<br>rtificat                     |                       |                             |                  | ental Hy                       | gien<br>Reg. N                    | $2 \Pi$         | 08                               | n L            | 47                  |
|---|-----------------|---|---|-------------------------|---------------|-------------------------------|--|-----------------------|-----------------------------|------------------|--------------------------------|-----------------------------------|-----------------|----------------------------------|----------------|---------------------|
| <b>5%</b>   | 50              | Decedent's Name (First, Middle  | , Last)   |                         |               |                               |  |                       | - Journ                     |                  | 2. Date of D                   |                                   | D): As          | -                                | 3. Time        | of Death            |
| Physicia  |                 | Jean M. Zirkl   | e   |                         |               |                               |  |                       |                             | FE               | BAUBF                          | ry P                              | ٧, i            | 8000                             | 11:            | 20A N               |
| /Medica<br>Examine  |                 | 4a. Facility Name (If not institution Saint Josep   | , give street and n                               | umber)                  | Cent          | ter                           | 4b. City,                              | Town, or              | Location (                  | of Death<br>OWSO | n                              | 40                                | c. County       | of Death                         | imor           | . е                 |
| Funeral   |                 | 5. Social Security Number   | 6. Sex  | 7. Age                  | e (In yrs. la | ast birthday)                 | If Under<br>Months                     | 1 Year<br>Days        | If Under<br>Hours           | 24 Hrs.          | 8. Date of B                   | irth                              | 1               | 9. Birthp                        | lace (Stat     | te or Foreig        |
| Director  |                 | 218-05-9362   | 1 □ M 2 🙀 F                                       | 8                       | 8             | Yrs.                          | IVIONINS                               | Days                  | Hours                       | IVIII.           | March                          |                                   |                 | Couir<br>Mary                    |                |                     |
| p v   |                 | Usual Residence of Decedent  10a. State 10b. County   |   |                         | 10c. City     | , Town or Lo                  | cation                                 |                       |                             |                  |                                |                                   |                 | T-                               | Od Inside      | City Limits         |
| farylan<br>show<br>ed at  | 5               |   | imore   |                         | Tows          |                               |  |                       |                             |                  |                                |                                   |                 |                                  |                | es 2 🔀 No           |
| the N<br>28a-i<br>notifi  | Director        | 10e. Street and Number  |   |                         |               |                               | 10f. Zip                               | Code                  |                             |                  |                                | 10g. C                            | itizen of V     | What Cour                        | ntry?          |                     |
| 3a or   | ٥               | 111 West Road   |   |                         |               |                               |  | 212                   | 'በ <b>4</b>                 |                  |                                | USA                               | 1               |                                  | ·              |                     |
| death   | Funeral         | 11. Marital Status  | 12. Was De  |                         | ever in U.S   | S. 13.                        | Was Dece                               |                       |                             | igin? (Spe       | ecify Yes or N<br>Rican, etc.) |                                   | 14. Rac         |                                  | an Indian,     |                     |
| after<br>or ite   | 2               | 1 ☐ Never Married 2 ☐ Marri   |   | 2X7N                    | 10            |                               | ii res, spe<br>1 ⊟ Yes                 |                       | Specify:                    |                  | nicari, etc.)                  |                                   | Specif          | k, White,<br>Wh                  | eic.<br>nite   |                     |
| ural",  | d by            | 3X Widowed 4 □ Divorced   | Year or   | Dates:                  |               |                               |  |                       |                             |                  |                                |                                   |                 | · ·                              |                |                     |
| "natı   | lete            | 15. Decedent<br>(Specify only highes  | 's Education<br>of grade completed                | d)                      |               | 16a. Dece<br>(Give            | dent's Usua<br>kind of wo<br>DO NOT us | al Occup<br>rk done ( | ation<br><i>during m</i> os | st of worki      | ng                             | 16b. I                            | Kind of Bu      | usiness/In                       | dustry         |                     |
| withir<br>ene.<br>than<br>he M  | Completed       | Elementary/Secondary (0-12)   | College   | (1-4or 5<br>1           | +)            |                               | Homem                                  |                       |                             |                  |                                |                                   | )wn F           | Iome                             |                |                     |
| filled<br>Hygi<br>other<br>ent, t   | Be C            | 17. Father's Name (First, Middle,   | Last)   |                         |               |                               |  |                       | 18. Mothe                   | er's Name        | (First, Middl                  | e, Maide                          | n Surnan        | ne)                              |                |                     |
| lid be<br>fental<br>rked o  | To B            | Thomas Parkison   | Mitchel:  | 1                       |               |                               |  |                       | Mal                         | bel E            | . Johr                         | nson                              |                 |                                  |                |                     |
| 2 should be filed within 72 hours after death with the Maryland and Mantal Hyglene. Is marked other than "natural", or items 23a or 23a-f show aumatic event, the Medical Examiner must be notified at  |                 | 19a. Informant's Name/Relationsh  |   |                         |               | 19b. Maili                    | ng Address                             | (Street               |                             |                  | al Route Num                   |                                   | or Town,        | State, Zip                       | Code)          |                     |
| and 2<br>ealth<br>n 27 I  |                 | Carol Sommer  | I   | Daug                    | hter          |                               |  |                       |                             |                  | re; Lut                        |                                   |                 |                                  |                |                     |
| jes 1<br>t of He<br>if iten   |                 | 20a. Method of Disposition 1   Burial 2 □ Cremation   | 3 □Removal fror                                   | n State                 | 20b. Pl       | lace of Dispo<br>emetery, cre | sition (Nar<br>matory or c             | ne of<br>other plac   | e)                          |                  | ate                            | 20c. l                            | _ocation -      | City or To                       | wn, State      | 5                   |
| Pages tment of I tant: If its jury or o   |                 | 4 ☐ Donation 5 ☐ Other (S <sub>i</sub>  | pecify)   |                         | Woo           | odlawn                        | Ceme                                   | tery                  | 7 2                         | 2/15/            | 2008                           | Wood                              | 11awr           | ı, Ma                            | rylar          | ıd                  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at once. |                 | 21. Signature of Emeral Service   | ∟icepsee  | 41                      |               | F                             | 2. Name ar<br>unera                    | d Addre               | ss of Facili<br>me of       | y Ste<br>f Cat   | rling<br>consvil<br>nue; Ca    | Ashi<br>Lle,                      | ion S<br>Inc,   | Schwa                            | b Wit          | :zke                |
| 22200   | -               | 23a Part 1 Enter the disease or   | complications that                                |                         | the death     |                               |  |                       |                             |                  |                                |                                   | svil]           | le, M                            | D 212 Approxin |                     |
| 4   |                 | 23a. Part1. Enter the disease, or<br>shock, or hearteallure. List<br>Immediate Cause (Final |   |                         |               |                               |  | ic or dyn             | ig, 50011 00                | o caraiao c      | or respiratory                 | arrest,                           |                 |                                  | Interval l     | Between<br>nd Death |
| Physician<br>/Medical   |                 | disease or condition<br>resulting in death)   | a   |                         | a consequ     | BOWEL                         |  |                       |                             |                  |                                |                                   |                 | -                                |                |                     |
| Examiner  |                 |   |   |                         |               | ACTIO                         | N                                      |                       |                             |                  |                                |                                   |                 |                                  |                |                     |
|   | Jer.            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying          | b. Due to   | o (or as a              | a consequ     | ience of):                    |  |                       |                             |                  |                                |                                   |                 |                                  |                |                     |
| cuted<br>nd<br>ransit   | Examiner        | that initiated events   | с   |                         |               |                               |  |                       |                             |                  |                                |                                   |                 |                                  |                |                     |
|   |                 | resulting in death) Last  | Due to  | o (or as a              | a consequ     | ience of):                    |  |                       |                             |                  |                                |                                   |                 |                                  |                |                     |
| rate bright   | dical           |   | d   |                         |               |                               |  |                       |                             |                  |                                |                                   | -               |                                  |                |                     |
| ding page as  | Me              | IF FEMALE:  | 23c. If yes, o                                    | utcome                  | nf pregna     | nev                           |  |                       |                             |                  |                                |                                   |                 |                                  |                |                     |
| death certific<br>attending p   | sian            | 23b. Was decedent pregnant in the past 12 months?   | 1 ☐ Live  | birth                   | 2 ☐ Fetal     | death 3[                      | ⊒Ectopic p                             |                       | ,                           |                  |                                | İ                                 |                 | te of deliv<br>onth              | ery<br>Day     | Year                |
| the d   | ysic            | 1 ☐ Yes 2 🗷 No<br>9 ☐ Unknown   | 9□Unk   |                         | time of de    | Jan J                         | _ Other (sp                            | )CONY/                |                             |                  |                                |                                   |                 |                                  |                |                     |
| ires that the de<br>signed by the a<br>be detached i  | by Physician/Me | Part II. Other significant condition  | ns contributing to                                | death bu                | ut not resu   | ılting in the u               | nderlying o                            | ause giv              | en in Part I                | ı.               | 23e. Did                       | l tobacco                         | use cont        | ribute to t                      | he cause       | of death?           |
| quires<br>n sign  | g<br>p          | CONGESTIVE HEAD   | RT FAILUF   | RE                      |               |                               |  |                       |                             |                  | 1 🗆                            | Yes :                             | 2 <b>K</b> ] No | 3 ☐ Prol                         | oably 4        | □Unknow             |
| aw requir<br>s been sis<br>2 should b   | Completed       | DIABETES MELLI  | rus   |                         |               |                               |  |                       |                             |                  | 24a. Wa                        |                                   | 24b.            | Were auto                        | psy findin     | ıgs availab         |
| The lav   | E               | PERIPHERAL VAS  | אר מא דווי  | FACI                    | r.            |                               |  |                       |                             |                  | per                            | opsy<br>formed?<br>2 <b>K</b> ] N | lo              | prior to co<br>death?<br>1 □ Yes |                | of cause of         |
| Physician: The la<br>r this certificate har<br>ral director, page 2   | Bec             | 25. Was case referred to medical examiner?  |   | ) <u>LAJ</u>            |               |                               |  |                       |                             | e of Death       | (Check only                    |                                   |                 |                                  |                |                     |
| hysic<br>his ce<br>al dire  | ဥ               | 1 ☐ Yes 2 No  |   | Inpatie                 |               | ER/Outpatier                  |  |                       | 4 ⊔ Ni                      |                  | me 5□Re                        |                                   |                 |                                  | fy)            |                     |
| ding Ph<br>n.<br>After th<br>funeral  | :io             | 27. Manner of Death 1 X Natural 5 ☐ Pending   | 9 1 '   | e of Injui<br>onth, Day |               | 28b. Time of<br>Injury        |  | 28c. Injur<br>Wor     |                             |                  | 28d. Describe                  | e how inj                         | ury occur       | red                              |                |                     |
| ttend<br>death.   | cati            | 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r   | not be 290 Place                                  | ce of init              | In/ - At ho   | me, farm, st                  | M factor                               |                       | Yes 2 🗌                     |                  | 28f. Location                  | (Stroot )                         | and Numi        | or or Pur                        | al Pouto A     | lumbor              |
| al or A<br>s after of<br>I Direct<br>d in by  | Certification:  | 4 ☐ Homicide determ   | ned buil  | lding, etc              | c. (Specify   | ()                            | cot, lactor                            | y, omoc               |                             | 1                | City or T                      | own, Sta                          | te)             | er or nur                        | ai rioute i    | umber,              |
|   | Medical C       |   | g Physician: To the<br>Examiner: On the<br>and ma |                         | f examinat    |                               |  |                       |                             |                  |                                |                                   |                 |                                  |                | se(s)               |
| To the within To the Somple   | Me              | 29b. Signature and title of certifier   |   | ,                       |               |                               | 29                                     | c. Licens             | e number                    |                  |                                | 29d. D                            | ate signe       | d (Month,                        | Day, Yea       | r)                  |
|   |                 |   | Kn  |                         |               |                               |  | D                     | 3725                        | 4                |                                |                                   | 2/1             | 0/0                              | E              |                     |
| 9/  |                 | 30. Name and address of person  |   |                         |               |                               |  |                       |                             |                  |                                |                                   |                 |                                  |                |                     |
| 0   |                 | BOON POH LIM  | 4. M.D  | , 76                    | 501           | OSLEF                         | DRI                                    | VE,                   | TOW                         | ISON,            | MAR'                           | YLAN                              | AD E            | 1204                             | -              |                     |

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 1 5 2008

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:39 P<sup>M</sup> CHARLES STEPHEN ZRALY 12, 2008 February /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPICE OF BALTO @ GILCHRIST CENTER Towson Baltimore County If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 1939 New York 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Davs Hours 1**∑**M 2□F 68 29, 075-30-5452 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Marylan 1 ☐ Yes 2 No Director Baltimore County Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a or 21212 420 Dumbarton Road **USA** Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 58-61 1 Never Married 2 Married 2 1 ☐ Yes 2 ☑ No Specify: Specify: White Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Year or Dates: 'natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Aerospace Production Engineer and Mental Hygie is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles H. Zraly Marion Mabel Bryant 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is
any injury or other trau 420 Dumbarton Road, Baltimore, Maryland 21212 of Disposition (Name of Date 20c. Location - City or Town, State Barbara A. Zraly (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Green Mount Crematory 2/15/2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) MITCHELL-WIEDEFELD FUNERAL HOME, INC. Maryland 21212 21. Signature of Funeral Service Lice se 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) STROINTESTINAL 40UPS **Physician** Tie to (or as a consequence of): /Medical **Examiner** ASTRITIS Sequentially list conditions. n any, reading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CHRONIC MYELOMONOCYTIC P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown EMPHUSEMA PULMONARY FIBROSIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No INSUFFICIENCY 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY 13.2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MO 21204 6565 MORTH CHAPLES STREET, SUITE 209 DANIEUE DOBELMAN, MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #18 Per FH G876 2/20/08 Per State of Death Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day **Physician** 0455 A.M 27 2008 William David Arterburn Jan. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Carroll Hospital Center Westminster 8. Date of Birth (Month, Day, Year) July 17, 1950 If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Maryland 1 ☑ M 2 □ F 219-54-4203 57 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2☐No Director Maryland Carroll Mt. Airv 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21771 United States 2473 Braddock Road Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Mayes 2 No 1969.
If Yes, Give Year or Dates: 1970 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: þ 1970 white 72 hours 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) 12th College (1-4or 5+) Builder Contractor 18. Mother's Name (First, Middle, Maiden Surname)
Wollnerhausen
Wildred Vulnerhausen 17. Father's Name (First, Middle, Last) Be William Carr Arterburn ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important; if item 27 is m any Injury or other 1 2473 Braddock Road Mt. Airy, MD 21771 Judy L. Arterburn wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

South Carroll Crematory Jan. 29, 2008 Winfield, MD 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Denation 5 □ Other (Specify) 22. Name and Address of Facility
Burrier-Oueen. Funeral Home. & Crematory, PA
1212 W. Old Liberty Road Winfield, MD 21784 21. Signature Funeral Service Licen 23a. art1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate rause (Final disease or condition resulting in death) metastatic 630phagen Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, THE TO JUST BY A CONSEQUENCE OF if any, leading to immedite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an cate has page 2 s this certificate 1□ Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation Injury 1X Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DUMNYWTW MD 1 51705 1-27-08

WILL

31. Date filed (Month, Day, Year)

JAN 3 1 2008

M. PANSURIYA

349 Mulwlm 32. Regionar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hestminster my 2115

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician  $a^{\text{M}}$ **3**0 2008 8:30 January Leonard Stanley Bowlsbey, Jr /Medical 4c. County of Death 4b. Citv. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sykesville Carroll Fairhaven Retirement Community If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1**∑**M 2□F Sept 09 1930 Director 220-32-3152
Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County a or 28a-f show t be notified at 1 ☐ Yes 2 XNo Finksburg Carrol1 MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21048 1600 Green Mill Road iral", or items 23a Examiner must b Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1952 11. Marital Status Black, White, etc. after 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1954 1 ☐ Yes 2 ☐ No Specify: þ within 72 hours 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed withi if Health and Mental Hygiene. Item 27 is marked other than Western MD College Dean of Graduate School 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche F. Ford Leonard Stanley Bowlsbey, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1600 Green Mill Road Finksburg, MD JoAnn Bowlsbev/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 02/02/2008 Calvert, MD Friends Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Henorrhagic cerebougscular accident Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a const quence of): Examiner Worday artery MISCACO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): criphical arter death certificate be executed direate burial-transi Exami and Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the aid be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has autopsy 1□ Yes 2 No ours after death.

neral Director: After this certifical in by the funeral director, it filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA e 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Certification: (Month, Day Year) Injury Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 17065000 30

WIL 15+IVA

> State Registrar

7200 3rd Avenue Anna Sarante, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year) FEB 0 1 Sykesville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Britton, Jr. Luther 8:40 P 29 2008 Sherman January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Country Meadows Retirement Comm. Frederick Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 15d M 2 □ F Yrs. Director 235-20-8562 92 July 25, 1915 | West Virginia Usual Residence of Decedent the Maryland 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show ns 23a or 28a-f shor must be notified at West 1 ☐ Yes 2 X No Director Virginia Morgantown Monongalia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23a 3417 Halleck Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturar; or items 23s any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must ponce. United States by Funeral 26508 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Farming Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luther Sherman Britton, Sr 2 Pearl Rogers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia McGill/ Daughter 10800 Chestnut Grove Circle, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Britton Family Farm Feb. 8,2008 \_Morgantown, WV 21. Signature of ineral Service 22 Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Bronsen disease or condition resulting in death) /Medical r as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical SE attending p IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 □Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform this certificate har ral director, page tal or Attending Physician: These after death.

al Director: After this certificate ed in by the funeral director, par To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours aff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Robert L. Kaufmahn, M.D. 300 W. Ninth Street 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Frederick, Maryland 21701

no

| ре                         | end #1<br>r FD,<br>6/08,d  | CC                         |  | E Type or Pr<br>State of N                                       |                                |                                       | <b>delible In</b><br>artment of                                   |                       |                           |  |             |                                      | ).                           |   |
|----------------------------|--|----------------------------|--|--|--------------------------------|---------------------------------------|---|-----------------------|---------------------------|--|-------------|--------------------------------------|------------------------------|---|
|                            |  |                            | 1 - State<br>Registrar   |  |                                |                                       | rtificate o   |                       |                           |  | Reg. No     | 211                                  | 08                           | 04475   |
|                            | Physici  | an :                       | 1. Decedent's Name (First, Middle, L   | ,  | _1                             |                                       |   |                       |                           | 2. Date of Dea<br>Month                  | Day         |                                      | ar                           | 3. Time of Death                                  |
|                            | /Medi<br>Examir  |                            | Nancy Lo  4a. Facility Name (If not institution, g   |  | aker_                          |                                       | 4b. City, Town  | , or Location         |                           | Januar                                   |             | O, 200 County of D                   |                              | 1:59 A <sup>M</sup>                               |
|                            | Examili  | lei                        | Caring Hearts  |  |                                |                                       | Bow   | ie                    |                           |  |             | Prin                                 | ce G                         | eorge's   |
|                            | Funeral<br>Director  |                            | 5. Social Security Number 577–50–2282  Usual Residence of Decedent   | Sex 7.1  | Age (In yrs. 72                | las <i>t birthday)</i><br>Yrs.        | If Under 1 Yes Months Day   |                       | er 24 Hrs. 8<br>Min.      | B. Date of Birth<br>(Month, Day<br>Aug 3 | v, Year)    | 1935 <sup>9.</sup>                   | Birthplac<br>Country<br>Wash | ce (State or Foreign<br>)<br>ington, DC           |
|                            | Maryland<br>-f show<br>fied at   | tor                        | 10a. State 10b. County   | e George's   |                                | y, Town or Lo                         |   |                       |                           |  |             |                                      | 10d                          | . Inside City Limits 1 ☐ Yes 2 ☑ No               |
|                            | n with the<br>3a or 28a<br>st be notii   | al Director                | 10e. Street and Number<br>6809 Louise La   | ne   | -1                             |                                       | 10f. Zip Code   | 0735                  |                           |  | 10g. Cit    | izen of What                         | Country                      | 1?  |
| 9036                       | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.                                  | by Funeral                 | 11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced   | 12. Was Deceder Armed Force 1  Yes 25 If Yes, Give Year or Dates | s?<br>∑No                      |                                       | Was Decedent of If Yes, specify C                                 |                       |                           | ify Yes or No-<br>ican, etc.)            |             | 14. Race - A<br>Black, W<br>Specify: | /hite, etc                   |   |
| 21215-0036                 | vithin 72 h<br>me.<br><b>han "natu</b><br>e Medical  | Completed                  | 15. Decedent's (Specify only highest g   | Education<br>trade completed)<br>College (1-4c                   | or 5+)                         | 16a. Dece<br>(Give<br>life.           | dent's Usual Occ<br>kind of work don<br>DO NOT use ret<br>Housewi | ne during mo<br>ired) | ost of working            | ,  | 16b. K      | ind of Busine                        |                              |   |
| d 2                        | filed v<br>Hygie<br>other 1  | ပ္ပိ                       | 17. Father's Name (First, Middle, La.  | st)  |                                |                                       | HOUSEWI   |                       | her's Name (              | First, Middle,                           | Maiden      | Own I                                | 101110                       |   |
| Marvland                   | Ald be Alental rked c  | To Be                      | Alexander A.   | Covingt  | on .                           | Caring                                | <del>ston</del>   | F                     | auth                      |  |             | I                                    | Ross                         |   |
| arv                        | 2 should and his ma  |                            | 19a. Informant's Name/Relationship   |  |                                | 1                                     | ng Address (Stre  |                       |                           |  |             | or Town, Stat                        | te, Zip C                    | ode)  |
| <u>ح</u><br>ته             | 1 and<br>Health<br>Sm 27<br>ther tr  |                            | Clarence Paul Ba   | ker (husba   | •                              |                                       | Louise  |                       |                           | ton, M                                   |             | 20735<br>ocation - City              | or Tour                      | Stato   |
| Baltimore.                 | t. Pages<br>trment of h<br>tant: If Ite  |                            | 1 ☑ Burial 2 ☐ Cremation 3<br>4 ☐ Donation 5 ☐ Other (Spec   | cify)  | le                             | dar Hi                                | osition (Name of matory or other p 11 Cem.                        |                       | Feb <sup>Da</sup><br>2008 | 3  | Su          | itland                               | d, M                         | D   |
| Ba                         | permii<br>Depar<br>Impor<br>any Ir   |                            | 21. Signature of Furieral Service Lic  | ensee<br>Goff  |                                |                                       | 2. Name and Ado $3125~{ m Sou}$                                   |                       | nee                       | Funera                                   |             | lome Ca<br>Owings                    |                              |   |
|                            | Physician<br>/Medical<br>Examiner  | iner                       | 23a. Part1. Enter the disease, or of shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to liminediate cause. Enter Underlying Cause (Disease or injury | a. Due to (or a  | line.                          | n. Do not ent<br>X<br>uence of):      | ter the mode of o   |                       | as cardiac or             |  |             | On 1116.                             | A III                        | pproximate interval Between onset and Death LOCKS |
| Box 68760.                 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Medical Examiner | IF FEMALE: 23b. Was decedent pregnant  | C  |                                | incy _                                | Estania pragna  |                       |                           |  |             | 23d. Date of                         | delivery                     |   |
| P.O. B                     | ries that the deati<br>signed by the atte  | hysicia                    | in the past 12 months?<br>1 □ Yes 2 ☑ No<br>9 □ Unknown  | 4☐Pregnant<br>9☐Unknowr  | at time of d                   |                                       | ⊒Ectopic pregna<br>⊒Other <i>(specify)</i>                        |                       |                           |  |             | Month                                | D                            | ay Year   |
|                            | w requires tha<br>been signed<br>should be det   | þ                          | Part II. Other significant conditions  Stroke  | contributing to death  | but not resu                   | ulting in the u                       | nderlying cause   | given in Part         | · I.                      |  |             | use contribut                        |                              | cause of death?                                   |
| Division or Vital Records. | The law re<br>cate has be  | Completed                  |  |  |                                |                                       |   |                       |                           | 24a. Was a autop perfor                  | sy<br>rmed? | prior<br>deat                        | to comp<br>h?                | y findings available<br>letion of cause of        |
| Vita                       | sician<br>certific   | Be                         | 25. Was case referred to medical examiner?   | Hospital:  |                                |                                       |   |                       |                           | Check only o                             |             |                                      |                              | hospice   |
| on or                      | nding Physician: The th. th. : After this certificate his funeral director, page   | tion: To                   | 1 Yes 2 X No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigati  | 28a. Date of li  |                                | ER/Outpatier<br>28b. Time o<br>Injury | f 28c. Ir   | 4 LI N                | 28                        | e 5 ☐ Resid<br>id. Describe h            |             |                                      | Specify)                     | section   |
| Divisi                     | To the Hospital or Attenwithin 24 hours after death To the Funeral Director:   | Certification:             | 3 Suicide 6 Could not determine  | a Zee. Place of  | Injury - At ho<br>etc. (Specif | ome, farm, str<br>y)                  | reet, factory, offic  | e                     | 28                        | f. Location (S<br>City or Tow            |             |                                      | r Rural f                    | Route Number,                                     |
|                            | he Hospitt<br>n 24 hours<br>he Funera<br>pletely fille   | Medical C                  | (Check only 2 Medical Ex   | Physician: To the be<br>aminer: On the basis<br>and manner       | of examina                     | tion and/or in                        | vestigation, in m   | y opinion, de         | eath occurred             | d at the time,                           | date an     | d place, and                         | due to the                   | he cause(s)                                       |
|                            | To ti<br>withi<br>To ti  | M                          | 29b. Signature and title of certifier  Many  | Hing.  | MO                             |                                       | 29c. Lice   | nse number            | 9041                      | (Mct)                                    | 29d. Da     | te signed (M                         | 31,                          | ay, Year)<br>2008                                 |
| di                         | w 5  |                            | 29b. Signature and title of certiffer  Mary  30. Name and address of person wh  Nancy Rivera  31. Date filed (Month, Day, Year)  FEB   | o completed cause o<br>King, m,                                  | f death (Item                  | 23a) (Type,<br>209A                   | Print) Mard   | a Lar                 | re, Ar                    | napoli                                   | 5           | mp                                   | 2/4                          | 103   |
| 6                          | Sta<br>Regist  | -                          | 31. Date filed (Month, Day, Year)  | 4 2008   | strads Signa                   | ture                                  | Aparte  |                       |                           |  |             |                                      |                              |   |

Division or Vital Records, P.O. Box 68760,

|  |  | _ For  | Plea                      |                        |                           |                                       |                              |  | . Ensure A<br>Health and I                | -                        |                | gible.                     |  |
|--|--|--|---------------------------|------------------------|---------------------------|---------------------------------------|------------------------------|--|---|--------------------------|----------------|----------------------------|--|
|  | •  | 1 - State<br>Registrar   |                           |                        |                           |                                       | Cei                          | rtificate of                           | Death                                     |                          | Reg. No. 2     | 008                        | 04476  |
| Physicia   | an   | 1. Decedent's Nam  |                           | e, Last)               |                           |                                       |                              |  |   | 2. Date of De<br>_ Month |                | _ Year                     | 3. Time of Death                                 |
| /Medic   | _  |  | velyn                     | G.                     |                           | rnsle                                 | ey                           |  |   | Januar                   | <del></del>    | 2008                       | 1:30 PM M  |
| Examin   | er   | 4a. Facility Name (  |                           |                        |                           |                                       |                              |  | or Location of Deatl                      | h                        |                | inty of Deat               |  |
|  | 2  | 5. Social Security N   |                           | ille Ro                |                           | ie (In vrs. la                        | ast birthday)                | If Under 1 Year                        | erick<br>                                 |                          | th             | deric                      | K hplace (State or Foreign untry)                |
| Funeral<br>Director  |  | 217-32-  |                           | 1 □ M 2 <b>X</b>       | F                         | 73                                    | Yrs.                         | Months Days                            | Hours Min.                                | July 1                   |                |                            | uintry)<br>(arvland                              |
| pu ,   |  | Usual Residence o  | f Decedent<br>10b. County |                        |                           | 10c City                              | , Town or Lo                 | cation                                 |   |                          |                |                            | 10d. Inside City Limits                          |
| laryla<br>shov   | 'n   | Md.  |                           | ederick                |                           | Toc. City                             | Frede                        |  |   |                          |                |                            | 1 ☐ Yes 2 ☑No                                    |
| the M<br>28a-f   | Director   | 10e. Street and Nu   |                           | deller                 |                           |                                       |                              | 10f. Zip Code                          |   |                          | 10g. Citizen   | of What Co                 | ountry?  |
| 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at   | Ö  | 5814 Ba  |                           | .lle Roa               | đ                         |                                       |                              |  | 21704                                     |                          | Ü              | nited                      | States   |
| deatl  | Funeral  | 11. Marital Status   |                           | 12. Was                | Decedent<br>d Forces?     | Ever in U.S                           | S. 13.                       | Was Decedent of H                      | Hispanic Origin? (S<br>an, Mexican, Puerl | pecify Yes or No         | 14.            | Race - Ame<br>Black, White | rican Indian,                                    |
| or ite   |  | 1 Never Mari   |                           | ried 1 🔲 \             | es 2 💢                    | No                                    | - 1                          | 1⊡Yes 2⊠ No                            |   | ,,                       |                | ecify:                     | White  |
| hours<br>tural"  | d by   | 3 Widowed  |                           | Year<br>it's Education | or Dates:                 | _                                     | 16a Decer                    | dent's Usual Occup                     | nation                                    |                          | 16b Kind o     | f Business/                |  |
| in 72<br>n "na<br>Medic  | Completed  |  | cify only highe           | st grade comple        |                           | F.)                                   | (Give                        | kind of work done<br>OO NOT use retire | during most of wor                        | rking                    | 100:1010       | , Buomood                  |  |
| d with<br>giene<br>rr thau   | mo   | Elementary/Seco  | ondary (0-12)             | Colle                  | ge (1-4or:                | 0+)                                   |                              | Homemake:                              | r   |                          | 0              | wn Ho                      | me   |
| al Hy<br>d othe  | Be   | 17. Father's Name  | (First, Middle,           |                        |                           |                                       |                              |  | 18. Mother's Nar                          | •                        |                | name)                      |  |
| Ment<br>Ment<br>arkec  | ၉  | Paul   | J.                        | Oland                  |                           |                                       |                              |  | Bessie                                    |                          |                |                            |  |
| 12 sh<br>h and<br>7 is m<br>traum  | 19a. Informant's Name/Relationship (Type. Print)   19b. Mailing Address (Street and Number or Rural Route Number of Rural Route Nu |  |                           |                        |                           |                                       |                              |  |   |                          |                |                            | Zip Code)<br>21704                               |
| 1 and<br>Health<br>em 27   | -4   | 20a. Method of Dis   |                           | 7 , 5                  |                           | 20b. PI                               | lace of Dispo                | sition (Name of                        | i   | Date                     |                |                            | Town, State                                      |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.   |  |  | Cremation                 | 3 □Removal f           | rom State                 |                                       |                              | <i>natory or other pla</i><br>ille Cem |   | 5/08                     | Lavt           | onsvi                      | lle, Md.   |
| Departme<br>Departme<br>Importan<br>any Injur  |  |  |                           |                        |                           |                                       |                              |  | <u> </u>                                  | <u> </u>                 |                |                            |  |
| Der<br>Imp   |  | 21. Signature of Funeral Service Licensee  Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. |                           |                        |                           |                                       |                              |  |   |                          |                |                            |  |
|  | 23a. Part1. Enter the disclase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |                           |                        |                           |                                       |                              |  |   |                          |                |                            | Approximate<br>Interval Between                  |
| Physician  |  | Immediate Cause<br>disease or condition  | níc                       | a GI                   | MVC                       | 176                                   | phic                         | lateral                                | sclero                                    | 515                      |                |                            | Onset and Death                                  |
| /Medical<br>Examiner   |  | resulting in death)  |                           | Du                     | e to ( as                 | a consequ                             | nce of):                     |  |   |                          |                |                            |  |
| A. Salar   | -  | Sequentially list co   | onditions,                | b. — Du                | e to for as               | a curiceyu                            | ence of:                     |  |   |                          |                | - 1                        |  |
| uted<br>d<br>ansit   | Examiner   | cause. Enter Under<br>Cause (Disease or<br>that initiated events   | erlying -<br>r injury     | <b>S</b> .             |                           |                                       |                              |  |   |                          |                |                            |  |
| e executed<br>ian and<br>urial-transit   |  | resulting in death)  | Last                      | C. Du                  | e to (or as               | a consequ                             | ence of):                    |  |   |                          |                |                            |  |
|  | ical   |  |                           | d                      |                           |                                       |                              |  |   |                          |                |                            |  |
| death certificate that the strending physical for use as the the control of the c | Physician/Medica   | IF FEMALE:   |                           | 220 If you             | outcome                   | of progna                             | Boy                          |  | -   |                          |                | D                          |  |
| attenc<br>for us   | ian/   | 23b. Was deceder<br>in the past 12   | 2 months?                 | 1 🗆 L                  | ive birth                 | pf pregna<br>2 □Fetal<br>t time of de | death 3                      | Ectopic pregnanc Other (specify)       | у   |                          | 23d.           | Date of del<br>Month       | Day Year   |
| at the de<br>by the a  | ysic   | 1 □ Yes 2.<br>9 □ Unknown  |                           |                        | Inknown                   | t time of ge                          | Jan 0 _                      |  |   |                          |                |                            |  |
| that<br>ned by<br>deta   | by Ph  | Part II. Other signi   | ificant conditi           | ons contributing       | to death t                | out not resu                          | ılting in the u              | nderlying cause giv                    | ven in Part I.                            | 23e. Did t               | obacco use     | contribute to              | the cause of death?                              |
| w requires that<br>been signed t<br>should be deta   |  |  |                           |                        |                           |                                       |                              |  |   | 1 🗆                      | Yes 2          | o 3∏Pi                     | robably 4 Unknown                                |
| ne taw re<br>has bee   | Completed  |  |                           |                        |                           |                                       |                              | _                                      |   | 24a. Was                 |                | prior to                   | utopsy findings available completion of cause of |
| The cate has page  | Com  |  |                           |                        |                           |                                       |                              |  |   |                          | ormed?<br>2 No | death?<br>1 ☐ Yes          | ,  |
| sician: Th<br>certificate<br>rector, pag   | Be (   | 25. Was case reference examiner?   | rred to medica            |                        |                           |                                       |                              | l Ott                                  | 205                                       | ath (Check only          |                |                            |  |
| Physical direction   | 2  | 1 Yes 2  | No                        |                        | 1 ☐ Inpati<br>Date of Inj |                                       | ER/Outpatier<br>28b. Time of | I SI DOX                               |   | lome 5 Resi              |                |                            | ecify)   |
| ding<br>h.<br>After<br>funer   | tion   | Natural 2 Accident   | 5 ☐ Pendii<br>invest      | ng (                   | Month, Da                 | y Year)                               | Injury                       | Wo                                     | rk?<br>]Yes 2 □ No                        | Zou. Dodonibo            | now injury o   | ,00,100                    |  |
| Atten<br>r deat<br>ector:<br>by the  | fica   | 3 Suicide  | 6 ☐ Could<br>determ       | not be 28e. F          |                           |                                       |                              | eet, factory, office                   |   |                          |                | umber or Ri                | ural Route Number,                               |
| s after  | Certification:   | 4 ☐ Homicide   | 2                         |                        | ouliaing, e               | tc. (Specify                          | '/<br>                       |  |   | City or 10               | wn, State)     |                            |  |
| To the Hospital or Attending F<br>within 24 hours after death.<br>To the Funeral Director: After<br>completely filled in by the funer.   | cal  | 29a. Certifier<br>(Check only  |                           |                        |                           |                                       |                              |  | ime, date and plac                        |                          |                |                            |  |
| the H<br>hin 24<br>the F<br>nplete   | Medical  | one)   |                           | and                    | manner s                  |                                       |                              | 29c. Licens                            |   |                          |                |                            |  |
| Vit.   | 2  | 29b. Signature and   | d title of certifie       | Umo                    | 9                         | M                                     | 0                            |  | 3642(                                     |                          |                |                            | th, Day, Year)                                   |
|  |  | 200 11   | A A A A 23                | uho complete i         |                           | donth //t-s                           | 222\ /T                      |  |   |                          | rebl           | uary                       | 1, 2008  |
| 0  |  | 30 Name and add  | ress or persor            | Who completed          | cause of (                | 9.093                                 | 2 Rid                        | cetald                                 | ()0 年(                                    | 04 Fa                    | des            | ch                         | MD 21701   |
| Sta  | te   | 31. Date filed (Mor  | _                         | 4 0000                 | 32. Figist                | rar's Signal                          | ture 1                       | geteld                                 | V- 1                                      |                          |                |                            |  |
| Registr  | ar   |  | FEB 0                     | 4 2008                 | Block                     | ر میں                                 | K M                          |  |   |                          |                |                            |  |

| )8-00934<br>Vilbur Joseph E  | loor   |  | oe or Print in<br>ate of Maryla        |                    |                                  |                                  |  |                                  | egible          | ).                 |                |  |
|--|--|--|--|--------------------|----------------------------------|----------------------------------|--|----------------------------------|-----------------|--------------------|----------------|--|
| Tilbai docopii 2   | ,001   | 1- For State Registrar   | ate or Maryla                          |                    | tificate o                       |                                  | no Mental                              | nygierie                         | Reg. No.        | 21                 | ากร            | R OLL T  |
| Physicia<br>Medical Exami  |  | Decedent's Name (First, Midd WILBUR                                | le,Last)<br>JOSE                       | РН                 | ВО                               | ONE SR.                          |  | 2. Date of D<br>Month<br>Februar | eath            | Year               |                | . Time of Death<br>1331 hrs                        |
| ,  |  | 4a. Facility Name (if not institution Southern Maryland H          | -                                      | mber)              |                                  | 4b. City, Town, o                | or Location of De                      |                                  | 4c.             | County of          |                |  |
| Funeral  |  | 5. Social Security Number  | ·                                      | 7. Age (In yrs. la | ast birthday)                    | If Under 1 Ye                    |  |                                  |                 | DD/YYYY)           | 9. Birthp      | lace (State or                                     |
| Director   |  | 217-32-3834  | 1 M 2 F                                | 71                 | Yr                               |                                  | ays Hours M                            | Aug                              | 8 193           | 6                  | Coun           | ASHINGTON<br>DC                                    |
| any  |  | Usual Residence of Decedent  10a. State 10b. County                |  | 10c. City,         | Town or Loca                     | tion                             |  |                                  |                 |                    | 1              | 0d. Inside City Limits                             |
| Maryland 28a-f show  | tor  |  | CE GEORGE'                             | S                  | LANDO'                           |                                  |  |                                  |                 |                    |                | Yes 2 No   |
| he Mary<br>or 28a  | Director   | 10e. Street and Number 2004 EAST MAI                               | RIBORO AVE                             | # 202              |                                  | 10f, Zip Code<br>20785           |  |                                  | US              | zen of Wha<br>A    | at Country     | <b>y</b> ?   |
| h with the ms 23a be not   | Funeral [  | 11. Marital Status   | 12. Was Dec                            | edent Ever in U.   | 10.3                             | as Decedent of F                 | lispanic Origin? (<br>an, Mexican, Pue |                                  | l               | 14. Race -         |                | n Indian, Black,                                   |
| er deatl   | Fun  | 1 Never Married 2 N  3 Widowed 4 X Div                             | arried 1 Y Yes orced If Yes, Give Year |                    | MY   "                           | Yes 2 X N                        |  | ito Ricari, etc.)                |                 | White,<br>Specify: |                | .ACK   |
| ours afi<br>satural'   | Specify:    Specify: |  |  |                    |                                  |                                  |  |                                  |                 |                    | iness/Ind      | ustry  |
| 36<br>nin 72 h<br>e.<br>than "r<br>cdical E  | Completed  | Elementary/Secondary (0-12) 6th                                    | College (1                             | -4 or 5+)          |                                  | CK DRIVE                         |  | retired)                         | P               | RIVAT              | ſΕ             |  |
| 5-0036 Led within 7 Hygiene. I other than  |  | 17. Father's Name (First, Middle                                   | , Last)                                |                    |                                  | 010 011212                       | 18.Mother's Na                         | me (First, Middl                 | e, Maiden       |                    |                |  |
| ID 21215-00; should be filed with and Mental Hygiene. 7 is marked other that event, the Med  | o Be   | VINCENT E. Bo  |  |                    | 19b, Mailir                      | a Address (Stre                  | KATTIE eet and Number                  | QUEE:                            |                 | tv or Town         | State 7        | in Code)   |
| MD d 2 should be and and and and and and and and and and   | ۲  | WILBUR J. BOO  |  |                    | 9018                             | SOUTH C                          | CHERRY L                               |                                  |                 |                    |                |  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  |  | 20a. Method of Disposition  1 Burial 2 Cremation                   | n 3 Removal fro                        |                    | Place of Dispo<br>crematory or o | sition (Name of c<br>ther place) | cemetery,                              | Date                             | 20c. I          | Location -         | City or To     | own, State   |
| Baltimore,<br>permit. Pages I ar<br>Department of Hes<br>Important: If ite<br>injury or other tr   |  | 4 Donation 5 Other S<br>21. Signature of Funeral Service           |  | RE                 |                                  | TION CEM<br>Name and Addre       | C F 111                                | 2/9/200<br>J. B. J               |                 |                    | _              |  |
|  |  | Nuah Fre   | derick                                 |                    |                                  |                                  | OVER RO                                | AD LAND                          | OVER,           | MARYI              | LAND           | 20785  |
| Physician<br>/Medical  |  | 23a. Part I. Enter the disease, or failure. List only one cause    | on each line.                          |                    |                                  | the mode of dying                | g, such as cardia                      | c or respiratory                 | arrest, sho     | ock, or hea        | rt             | Approximate Interval<br>Between Onset and<br>Death |
| taminer  |  | Immediate Cause (Final disease<br>or condition resulting in death) |  | consequence of     |                                  |                                  |  |                                  |                 |                    |                |  |
|  | Jer  | Sequentially list conditions, if any, leading to immediate         | b. Due to (or as a                     | consequence of     | ·):                              |                                  |  |                                  |                 |                    |                |  |
|  | Examine  | (Disease or injury that initiated events resulting in death) Last  | c.<br>Due to (or as a                  | consequence of     | ·):                              |                                  |  |                                  |                 |                    |                |  |
| xecuted<br>n and<br>- transit  | <u>_</u>   | E IMPENDED   | d                                      |                    |                                  |                                  |  |                                  |                 |                    |                | <del></del>  |
| 60,<br>ate be e<br>hysician  | Vedic  | Y UNPENDED   | #23a,PI                                | I,27,per           | ME, g876                         | , 2/29/08                        | TT                                     |                                  | 230             | d. Date of o       | delivery       |  |
| Box 68760, e death certificate be ex the attending physician ed for use as the burial  | cian/  | 23b. Was decedent pregnant in to<br>past 12 months?                | ne 1 Live bi                           |                    | 2 F                              | etal death 3                     | Ectopic pre                            | gnancy                           | 1001            | Month              | Da             | y Year   |
| Box<br>he death<br>the atte  | Physician/Medic  | 1 Yes 2 No 9 Un  | known 9 Unkno                          | wn                 | 30                               | ther (Specify)                   |  |                                  | į               |                    |                |  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician: completely filled in by the funeral director, page 2 should be detached for use as the burial. |  | Part II. Other significant condit<br>Hypertensive ath              | ū                                      |                    | •                                | underlying cause                 | e given in Part I.                     |                                  |                 | -                  |                | e cause of death?                                  |
| ords, w require ts been si should b  | leted  | -,,  |  |                    |                                  |                                  | -                                      |                                  | as an<br>itopsy |                    |                | psy findings available                             |
| Division of Vital Records, tal or Attending Physician: The law require its after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should b  | Completed by   |  |  |                    |                                  |                                  |  | pe                               | erformed?       | de                 | eath?<br>✔ Yes | 2 No   |
| Vital Recysician: The his certificate director, page   | Be   | 25. Was case referred to medica examiner?                          | Hospital                               | npatient 2         | ER/Outpatien                     |                                  | Other                                  | ck only one)                     | Reside          | unca 6             | Other:         |  |
| n of V<br>ding Phy<br>a.<br>After thi<br>funeral d   | n: To  | 1 Yes 2 No<br>27. Manner of Death                                  | 28a. Date (                            |                    | 28b. Time of                     |                                  | jury at Work?                          | 28d. Descri                      |                 |                    |                |  |
| ision<br>Attendi<br>r death.<br>ector:<br>by the f   | catio  | Natural 5 Peni<br>2 Accident Inve                                  | ding<br>stigation                      |                    | ma form atra                     | 1                                | Yes 2 No                               | 005 1                            | . (01           |                    |                | I Berta Market City                                |
| Divisior Hospital or Atteno 24 hours after death Funeral Director:   | Certification:   |  | d not be rmined (Specify)              | or injury - At no  | me, ram, sue                     | et, factory, office              | building, etc.                         |                                  | n (Street a     | na Numbe           | r or Rura      | Route Number, City                                 |
| To the Hospita Within 24 hours Completely fille  |  | Tolloon only   | hysician: To the besi                  |                    |                                  |                                  |  |                                  |                 |                    |                |  |
| To the within 2 To the complet   | Medical  | 2 Medical Example 29b. Signature and title of certific             | and manner st                          |                    | - Investige                      |                                  | nse number                             | u at the time, u                 |                 |                    |                | n, Day, Year)                                      |
|  |  | in 6   | ~, n                                   | 5                  |                                  | 0.0                              | C.M.E.                                 |                                  | Feb             | ruary 3,           | 2008           |  |
| R  |  | 30. Name and address of person<br>Ling Li, MD Assista              | who completed caus                     |                    |                                  | et, Baltimore                    | , MD 21201                             |                                  |                 |                    |                |  |
| St   | ate  | 31. Date filed (Month, Day, Year)                                  |  | gistrar's Signat   |                                  |                                  |  |                                  |                 |                    |                |  |
| Regist   | rar  | FEB 0 8 2008   | Black                                  | 15 15              |                                  |                                  |  |                                  |                 |                    |                |  |

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** VICGINIA OSALNETT 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TahirAur Morr Law

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. DEFUT Dazy Harpital Conter Word rong Wicomico Birthptace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🖫 F 86 Yrs. 258-22-0489 Director 2/18/1921 Georgia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show the Medical Examinary must be notified at 1 ☐ Yes 2 🔀 No Director Maryland Wicomico Hebron 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21830 25965 Porter Mill road USA 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? or Iteme 11 Maritat Status filed within 72 hours after 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. þ Specify: white 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) Coltege (1-4or 5+) homemaker domestic other : If item 27 le marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be in nent of Health and Mental I ent: If item 27 le marked of Ruby Akins Paul L. Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25965 Porter Mill Rd., Hebron, MD 21830 W. Simpson Dunahoo/ son-in-law 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Barrow Memorial Department Importent: If any injury or once. 2/3/08 Winder, Ga \* 4 ☐ Donation 5 ☐ Other (Specify) Gardens permit. 21. Signature of Funeral Service Tensee 2HoT10Way Fufferal Home Professional Association Helf K 501 Snow Hill Rd., Salisbury, MD 21804 Menry 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS 20 Days /Medical Due to (or as a consequence of): **Examiner** Trace To OECUBITUS 15 Worth Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner physician and s the burial-transit The law requires that the death certificate be executed DEWENLIY - YTSheimAI yo LEDL Due to (or as a consequence of): Box 68760, as attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a P.O. 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 2 No 3 Probably 4 Unknown has been sign rottonged to NOVMONIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rector, page 2 No 1 Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. nours after death nerel Director: A investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tniury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours all To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medica (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified Tol 0 00 97237 1-31- 5008 30. ame and address of person who completed cause of death (Item 23a) (Type, Print) 1896 Budgara, good 1448 more sologed JUHLOTIMBU MID DATE Part MICHORO H 31. Date filed (Month, Day, Year) 32. Register's Signature State FEB 0 1 2008 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Aubrey Thomas Sr. Barnes a M January 28, 2008 7:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 722 Ebenezer Drive Wicomico Salisbury 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 73 227-38-7287 Director 4/28/1934 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at one. 10d. Inside City Limits 1⊈Yes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 722 Ebenezer Drive 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No δ Specify white 3 ☐ Widowed 4 🏿 Divorced Army Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 lineman utility company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (unknown) Barnes Emma Dennis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelby Barnes/daughter 722 Ebenezer Dr., Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Salisbury Crematory Salisbury, MD 4 □ Donation 5 □ Other (Specify) 1/30/08 21. Signature of Funeral Service License Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Kerli 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HEIZDSCLELITIC Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on. Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown director, page 2 should

**Physician** /Medical Examiner

and

be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Completed Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

been

certificate has

this

After

24 hours after death Funeral Director:

within 2.

funeral

filled in by

Medical

Division or Vital Records, P.O. Box 68760.

25. Was c - e referred to medical examiner?
1 □ Yes 2 □ No

5 Pending investigation

27. Mann of Death

1 Natural 2 Accident

29a. Certifier

24b. Were autopsy findings available prior to completion of oduse of death? autopsy performed 1 ☐ Yes 2 ☑ No 2 WNo

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Specify)

| _  |                        |        |                         |             |      | neck onlone       |             |
|--|------------------------|--------|-------------------------|-------------|------|-------------------|-------------|
| fospital: 1 ☐ Inpatient 2 ☐              | ER/Outpatient          | 3 🗆 DC | OA Other: 4             | ☐ Nursing H | ome  | 5 Residence       | 6 □Othe     |
| 28a. Date of Injury<br>(Month, Day Year) | 28b. Time of<br>Injury | 2      | 28c. Injury at<br>Work? |             | 28d. | Describe how inju | Jry occurre |
|  |                        | M      | 1 Tes                   | 2 🗌 No      |      |                   |             |

6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. e(s)

| one)                                | and manner stated. |                     | at the time, date and place, and due to the caus |
|-------------------------------------|--------------------|---------------------|--|
| b. Signature and title of certifier |                    | 29c. License number | 29d. Date signed (Month, Day, Year,              |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

) - 60515 1/2 SHINT DR. SALISBURY

State Registrar

|             |   | 1              | 1 - State<br>Registrar   | State of Maryl  |  | artment of H                                 |                                    |   | giene<br>Reg. No.20                   | 08 0448                                    | 0  |
|-------------|---|----------------|--|---|--|--|------------------------------------|---|---------------------------------------|--|----|
|             |   | -              | Decedent's Name (First, Middle, Last)  |   |  |  |                                    | 2. Date of Dea                            | ath                                   | 3. Time of Death                           | _  |
|             | Physici<br>/Medic   |                | ALFONSO  | TOMAS C   | ALDERON  |  |                                    | JAN.                                      |                                       | Year<br>008 11:59 P                        | N  |
|             | Examin  |                | 4a. Facility Name (If not institution, give st   | reet and number)  |  | 4b. City, Town, or                           | Location of De                     | eath                                      | 4c. County of                         | of Death                                   |    |
|             |   | æ              | WASHINGTON ADVE  |   |  | TAKOMA                                       |                                    |   |                                       | TGOMERY                                    |    |
|             | Funeral   |                | 5. Social Security Number 6. Sex   | M 2DE   | yrs. last birthday<br>Yrs.   | Months Days                                  | If Under 24 H<br>Hours M           | in. (Month, Da                            | y, Year)                              | Birthplace (State or Foreig<br>Country)    | าก |
| A**         | Director  |                | Usual Residence of Decedent  | 8   | 3 113.   |  |                                    | OCT. 2                                    | , 1924                                | ECUADOR                                    | _  |
|             | yland<br>sow  |                | 10a. State 10b. County   | 100   | . City, Town or L  | ocation                                      |                                    |   |                                       | 10d. Inside City Limit                     | s  |
|             | Mar-fat   | tor            | MD. PRINCE GEO   | RGES  | (  | COLLEGE PA                                   | ARK                                |   |                                       | 1 Yes 2 N                                  | 0  |
|             | or 28   | Director       | 10e. Street and Number   |   |  | 10f. Zip Code                                |                                    |   | 10g. Citizen of W                     | hat Country?                               |    |
|             | 23a   |                | 4711 BERWYN HOU  | SE RD. #61  | 0  | 20   | )740                               |   | EC                                    | UADOR                                      |    |
|             | tama<br>erra  | Funerai        | The state of the s | 2. Was Decedent Ever<br>Armed Forces?                                     | in U.S. 13.  | Was Decedent of H<br>If Yes, specify Cuba    | ispanic Origin?<br>In, Mexican, Pu | (Specify Yes or No-<br>lerto Rican, etc.) |                                       | - American Indian,<br>k, White, etc.       |    |
| 36          | illed within 72 hours atter death with the Maryland<br>Hyglene.<br>ther than "natural", or Itama 23a or 28a-f ahow<br>ant, I'ra Medical Examinat roust be malified at                 | by Fi          | 1 Never Married 2 Married 3 Widowed 4 Divorced   | 1 ☐ Yes 2X No<br>If Yes, Give   |  | X Yes 2 No                                   | Specify:                           |   | Specify:                              |  |    |
| 21215-0036  | hour  | edt            | 15. Decedent's Educa   | Year or Dates:  | 16a Dece   | edent's Usual Occup                          |                                    | DORIAN                                    | 16b. Kind of Bus                      | WHITE                                      |    |
| 7.          | in 72<br>n *na  | Completed      | (Specify onfy highest grade  | completed)  | (Give  | e kind of work done of<br>DO NOT use retired | during most of                     | working                                   | 160. Kind of Bus                      | siness/modstry                             |    |
| 212         | d with  | E              | Elementary/Secondary (0-12)  | College (1-4or 5+)  |  | CONTRACT                                     | OR                                 |   | CONST                                 | RUCTION                                    |    |
| פַ          |   | Be C           | 17. Father's Name (First, Middle, Last)  |   |  |  | 18. Mother's I                     | Name (First, Middle,                      | Maiden Surname                        | 9)   |    |
| <u>la</u>   | Mental<br>Mental<br>arked c   | ToE            | TEODORO  | CALDE   | RON  |  |                                    | DOLORES                                   | FL                                    | ORES                                       |    |
| Maryland    | S 50 50   |                | 19a. Informant's Name/Relationship (Type   | e, Print)   | 19b. Mail  | ing Address (Street                          | a <i>nd Number</i> or              | Rural Route Numbe                         | er, City or Town, S                   | State, Zip Code)                           |    |
|             | ges 1 and 3 of Health if item 27 or other tra   | - 1            | FE YOLANDA CALDERO   |   | and the second s |  | HOUSE RI                           |   |                                       | PARK, MD.2074                              | 0  |
| Ore         | Pages 1<br>nent of H<br>int: If iten  |                | 20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 ☐ Re   |   | Db. Place of Disp<br>cemetery, cre   | osition (Name of<br>ematory or other plac    | e)                                 | Date                                      | 20c. Location - 0                     | City or Town, State                        |    |
| Ë           | tmen<br>tant:   |                | 4 □Donation 5 □Other (Specify)   |   |  | CREMATOR                                     |                                    | 1-2008                                    |                                       | ALE, MD.                                   |    |
| Baltimore,  | permit. Pages. Department of It important; If ite any injury or of once.  |                | 21. Signature of Funeral Service Liperisee   | Aluna (D)   | M00091   | 2. Name and Address<br>CHAMBERS<br>5801 CLEV | s of Facility<br>FUNERAL<br>ELAND  | L HOME & AVE., RIV                        | CREMATOR<br>ERDALE,                   | IUM,P.A.<br>MD. 20737                      |    |
|             |   |                | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one  | ations that caused the cause on each line.                                | death. Do not er   | iter the mode of dyin                        | g, such as card                    | diac or respiratory ar                    | rrest,                                | Approximate<br>Interval Between            |    |
|             | Physician   |                | Immediate Cause (Final disease or condition  | PACTE   | noto   | DNY  | uma                                | 154                                       |                                       | Onset and Death                            |    |
|             | /Medical<br>Examiner  |                | resulting in death)  | Due to (or as a cor   | nsequence of):   |  | 7-01-0                             |   |                                       |  | _  |
|             | Ladillilei  |                | Sequentially list conditions, b.   | Acut  | E RE   | Mr I   | 2000                               | WE  |                                       |  |    |
|             | ed sit  | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | Due to (or as a cor   | isequence of):   | 0.7  |                                    |   |                                       |  |    |
|             | and<br>and<br>Il-tran   | хап            | that initiated events c. resulting in death) Last  | Due to (or as a cor   | sequence of):  | PERATOR                                      | 4 12                               | STUBO                                     | > 54N                                 | prome                                      |    |
| 8760,       | cate be executed<br>physician and<br>the burial-transit   | E E            |  |   |  |  |                                    |   |                                       |  |    |
| 687         | ficate<br>physics<br>to the   | edical         | d.   |   |  |  |                                    |   |                                       |  | _  |
| Box         | The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be detached for use as the burial-transit                    | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant  | c. If yes, outcome of pr  |  |  |                                    |   | 23d. Date                             | of delivery                                |    |
|             | death<br>e ette   | cia            | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   | 1☐Live birth 2☐<br>4☐Pregnant at time                                     |  | □Ectopic pregnancy<br>□ Other (specify)      | ·                                  |   | Mon                                   | ,  |    |
| Ö.          | that the de<br>ed by the<br>detached  | hys            | 9 Unknown  | 9□ Unknown  |  |  |                                    |   |                                       |  |    |
| S, D        | signed<br>be del  | by Р           | Part II. Other significant conditions conti  | ributing to death but no  | t resulting in the   | underlying cause give                        | en in Part I.                      | 23e. Did to                               | obacco use contri                     | bute to the cause of death?                |    |
| Records,    | w require<br>been signation   | bel            |  |   |  |  |                                    | 1 1                                       | Yes 2□No                              | 3 ☐ Probably 4 ☐ ☐ ☐ Know                  | 'n |
| ecc         | law ra<br>as be<br>2 sh   | Completed      |  |   |  |  |                                    | 24a. Was                                  |                                       | Vere autopsy findings availab              | le |
| ш<br>Ш      | The<br>ate h<br>page  | Con            |  |   |  |  |                                    | perfo                                     | rmed? de                              | eath? ☐ Yes 2 → No                         |    |
| Viital      | cian:<br>ertific<br>actor,  | Be             | 25. Was case referred to medical examiner?   |   |  |  | 26. Place of I                     | Death Check only o                        | ne                                    |  |    |
|             | this c  | မ              | 1 103 2 100  |   | 2 ER/Outpatie  |  | 4 🗀 Nursin                         | g Home 5 ☐ Resid                          |                                       |  |    |
| N C         | ling F  | ion:           | 27. Manner of Death 1 ☐ Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Yea                                    | 28b. Time (<br>Injury  | Worl   |                                    | 28d. Describe I                           | now injury occurre                    | ed .                                       |    |
| Sic         | Attending Physician: r death. actor: After this certific by the funeral director, i   | icat           | 2 Accident investigation 3 Suicide 6 Could not be  | 20a Place of Initial  | At home (a   |  | Yes 2 □ No                         | 006                                       | C44                                   | 0.10.11                                    |    |
| Division of | al or A<br>s after<br>il Diraci   | Certification: | 4 Homicide determined  | 28e. Place of Injury -<br>building, etc. (S)                              | pecify)  | reet, factory, office                        |                                    | City or Tov                               | vn, State)                            | er or Rural Route Number,                  |    |
|             | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Medical (      | 29a. Certifier 1 Solutying Physic (Check only one)   | cian: To the best of my<br>or. On the basis of exam<br>and manner stated. | knowledge, dea<br>mination and/or i  | th occurred at the tin                       | ne, date and pi<br>pinion, death o | ace, and due to the courred at the time,  | cause(s) and mar<br>date and place, a | nner as stated.<br>and due to the cause(s) |    |
|             | To the<br>Within<br>To the  | Me             | 29b. Signature and title of certifier  | stated.   |  | 29c. Licens                                  | e number                           |   | 29d. Date signed                      | (Month, Day, Year)                         |    |
|             | 1   |                | 1  | m. 0  | <  | De   | 5130                               | 77  | 01/2                                  | 30/98                                      |    |
|             | >   |                | 30. Name and address of person who com   | pleted cause of death   | (Item 23a) (Type   | , Print)                                     | 600                                | CANA                                      | 071 A                                 | VETULAS.                                   |    |
|             |   |                | DAWS MI  | Work  | NM   | 30   | Marie                              | Aury                                      | Anv                                   | MD 209                                     | C  |
|             | Sta   |                | 31. Date filed (Month, Day, Year)  | 32 Registrar's S  | Signature  |  | 1                                  | e and the                                 | 1                                     |  |    |
|             | Registi   | ar             | FEB 0 1 2008   | Bullion .   | K. B.  | RAPS 1                                       |                                    |   |                                       |  |    |

DHMH 17 Rev 1/2001

drw 10

State Registrar

DHMH 17 Rev 1/2001

GLYNIS A MOOY, MO NO
31. Date filed (Month, Day, Year) 32. Registration Sign

FEB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registraria Signature

Will

40

WOSPITAL DR, SUITE 310

12008

PRINCE FREDERICK, MO

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 28,2008 9:07 p <sup>M</sup> **Physician** Cobbs January David /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 7/21/1951 1 XM 2 □ I Months Days Hours Min. 228-74-0986 56 Director Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Prince Georges District Heights 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2112 Tiber Drive 20747 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify:Black \$ 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental I int: If Item 27 Is marked or Nathaniel Cobbs Venus Lipscomb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 19a. Informant's Name/Relationship (Type, Print) Ethel Booth/Friend 2112 Tiber Dr. District Heights, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or injury or Resurrection Clinton, Maryland 4 Donation 5 Other (Specify) 2/4/08 21. Signature un al Se rice I cen 22. Name and Address of Facility Adams Funeral Home PA 20605 Aquasco Rd. Aquasco, Maryland20608 191 23a. Part1. Enter the disease, or com shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Endre VASCular DISC Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner -transit death certificate be executed and Due to (or as a consequence of) burialphysician the burial Box 68760, Physician/Medical as IF FEMALE: nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) P.O. 9□Unknown p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ UniKnown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Division or Vital 25. Was case referred to medical examiner? 1 ▼Yes 2□ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ပ 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 ☐ Natural Injury 5 Pending death. investigation 1 Yes 2 No 2 ☐ Accident To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours after Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

State Registrar

31. Date filed (Month, Day, Year) 2008 FEB 0 1

title of certifie

(Check only one)

29b. Signature and

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

washista MD20744

medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JULIA MAUDE JULIA KING CREECH 8:40 P M CREECH AKA JANUARY 31 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 XF 579-22-9288 Director 93 28, 1915 Maryland Jan. Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show notified at 1 ☐ Yes 2 XNo Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 21701 Funeral 900 B Blueleaf Court Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ∐ Yes 2 💢 No þ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than " Wholesale Automotive Elementary/Secondary (0-12) College (1-4or 5+) Billing Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Reginald Windsor King Ida May Grimes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. Mrs. June Jordan, niece 900 B Blueleaf Court, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation Providence Methodist Cemetery Kemptown, Maryland 21. Signature of Fuy ral Service License 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each Approximate Interval Between Onset and Death Immediate Cause Final disease or continon resulting in death) **Physician** neumones /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 1 🗆 Yes signed by the a 9 Unknown 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown **Be Completed** 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 s 24a. Was an autopsy performed 2 No 2□ No 1□ Yes 1 Yes To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital 1 [ Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Watural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

31. Date filed (Month, Day, Year,

29b. Signature and title of certifier

gistrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

29c. License number

29d. Date signed (Month, Day, Year)

7) Frehenk, M/21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 505 -EB 05 TARRIETT 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner KENT HESTER RIVER MANOR HESTERTOWN If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 📈 F Hours 11811 Director APRIL Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 'natural", or items 23a or 28a-f show Examiner must be notified at 1 es 2 □ No CHESTERTOWN KENT Directo MD 10e. Street and Number MAGNOLIA 10f. Zip Code 10g. Citizen of What Country? 21620 U.S. 14 MANOR Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOTEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EMILY 34138 မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra ANNE WORTON MD -1678 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State HESTER CHESTELTOWN, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Mari , WILLIAMS, JR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CHESTERTUNN Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner auteusen Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of): burial-1 physician the burial Box 68760 Physician/Medical as been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Meterodustic VASculan Sisess 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has je 2 autopsy page performed? certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury death. 1 TYes 2 TNo 2 Accident within 24 hours after death To the Funeral Director: A completely filled in by the f 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of heath (Item 23a) (Type, Print) TR. M.D. 223 High Street, CHestertown, ned 21620 ARRABAL 31. Date filed (Month, Day, Year) 32. Registres Signature

Registrar

2008

|  | 1 - For<br>State<br>Registrar   | State of Maryla   | and / Dep                             |  | ealth and N   | Mental Hyg                                 | iene 200                               | 8 04485  |
|--|---|---|---------------------------------------|--|---|--|--|--|
| Physician<br>/Medical  | 1. Decedent's Name (First, Middle, L<br>Robin R. Crosel   | 1   |                                       | T  |   | 2. Date of Deat                            | 25 Ye.                                 | 08 1450 PM   |
| Examiner Funeral Director  | 4a, Facility Name (If not institution, g PENINSUA REGIL  5. Social Security Number  6. 267–51–0540  | onal Medical  | Center<br>yrs. last birthday,<br>Yrs. | 4b. City, Town, or Sall Shun If Under 1 Year Months Days                                   | 1, MD   | 8. Date of Birth (Month, Day, Dec 27,      | 4c. County of D<br>WICON<br>1962       | eath  Country)  MD                                 |
| Maryland I-f show fied at  | Usual Residence of Decedent  10a. State 10b. County  MD Wicomi  |   | City, Town or L                       |  |   |  |  | 10d. Inside City Limits 1 ☑Yes 2 ☐ No              |
| ath with the Mars 23a or 28a-f shoust be notified  | 647 Fitzwater St  | T   |                                       | 10f. Zip Code 2180   |   |  | 0g. Citizen of What USA                |  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director                     | 11. Marital Status  1   Never Married 2  Married 3  Widowed 4  Divorced   | 12. Was Decedent Ever in<br>Armed Forces?<br>1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates: | n U.S. 13.                            | Was Decedent of Hi<br>If Yes, specify Cuba<br>1 ☐ Yes 2√2 No                               | spanic Origin? (S)<br>n, Mexican, Puert<br>Specify: | pecity Yes or No-<br>p Rican, etc.)        |  | merican Indian,<br>/hite, etc.<br>.ack             |
| ed within 72 hou<br>lygiene.<br>her than "naturs<br>rt, the Medical E<br>Completed   | 15. Decedent's (Specify only highest g  |   | i (Give                               | dent's Usual Occupa<br>kind of work done of<br>DO NOT use retired                          | luring most of wor<br>)                             | king                                       | 16b. Kind of Busine                    | ss/Industry  |
| wuld be filed<br>Mental Hygi<br>arked other<br>atic event, t   | 17. Father's Name (First, Middle, La.  James E. Crosell   | st)   |                                       |  |   | ne (First, Middle, M                       |  |  |
| 1 and 2 sho<br>Health and P<br>PM 27 is ma<br>ther trauma  | 19a. Informant's Name/Relationship  Lamont Crosell/s  20a. Method of Disposition  | on  | 1407                                  | ng Address (Street a   | l St., Ba   | ltimore,                                   |  |  |
| mit. Pages<br>partment of l<br>cortant: If it<br>injury or o   | 1 Service 21. Sign on e of Fun 1 Service 21.  | GIA GIA   | reen Acı                              | osition (Name of<br>matory or other place<br>CES MEM Pa<br>2. Name and Addres<br>WIS N. Wa | rk   2/02   | 2/2008                                     | Salisbur                               |  |
| Physician  | 23a. Part1. Errer the disease, or co<br>shock, or heart failure. List on<br>Immediate Cause (Final<br>disease or condition  | mplications that caused the d<br>ly one cause on each line.                                   | leath. Do not en                      | 518 West F<br>ter the mode of dyin   | Rd., Sali<br>g, such as cardiad                     | sbury, Morrespiratory arre                 | D 21801<br>est,                        | Approximate<br>Interval Between<br>Onset and Death |
| rate be executed hysician and the burial-transit and the burial-transit and diffical Examiner  | resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a cons  | sequence of):                         | ARR<br>SIVE C  | CAR 010   | myo P                                      | ATHY                                   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has leen signed by the attending physicompletely filled in by the funeral director, lage 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome pf pre<br>1 ☐ Live birth 2 ☐ F<br>4 ☐ Pregnant at time<br>9 ☐ Unknown    | Fetal death 3                         | □Ectopic pregnancy<br>□ Other <i>(specify)</i>   |   |  | 23d. Date of<br>Month                  | delivery<br>Day Year                               |
| equires that en signed by ould be deta   | Tarri. Other significant conditions   | s contributing to death but not   | resulting in the I                    | inderlying cause give  | en in Part I.                                       | 23e. Did tob                               | (/                                     | e to the cause of death?  Probably 4 Unknown       |
| The la   |   |   |                                       |  |   | 24a. Was a<br>autops<br>perforr<br>1 Yes 2 | sy prior                               |  |
| g Physician<br>er this certifieral director  | 27. Manner of Death   | Hospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Yea.                                 | 2 ER/Outpatie                         |  | er:<br>4 ☐ Nursing H                                |  | ence 6 □Other (3<br>ow injury occurred | Specify)   |
| To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (  | 1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine   | be 280 Place of injury - A  | At home, farm, st                     | M 1□   | Yes 2□No  | 28f. Location (St<br>City or Town          |  | r Rural Route Number,                              |
| o the Hospital ithin 24 hours is the Funeral ompletely filled Medical Ce   | 29a. Certifier (Check only 2 Medical Ex   | Physician: To the best of my aminer: On the basis of examend manner stated.                   | mination and/or i                     | nvestigation, in my o  | pinion, death occu                                  | rred at the time, d                        | late and place, and                    | r as stated.<br>due to the cause(s)                |
| Tot Com  | 29b. Signature and title of certifier  30. Name and address of person wh  | ZNOAW, MC   | (Item 23a) (Type                      | 29c. License   | e number<br>420 75                                  | 2  | 9d. Date signed ( $N$                  | onth, Day, Year)                                   |
| State<br>Registrar   | EMMAPUEL NS; 31. Date filed (Month, Day, Year) FEB 0 1 20   | AH, 400 E S Hz. Registrar's Si  | ignature                              | Print)   | SBURY   | MQ   | 21804                                  | <i>‡</i>   |

08-00810

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Ypline Chumette 2008 04486 Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day January 29, 2008 Physician/ 1450 hrs 기 Examiner Yoline Chaumette 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Oxon Hill 2114 Alice Avenue #2 B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours 05/15/1952 Country) Haiti 55 Director 347-46-3406 Yrs M 2X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 X Yes 2 No P.G. Oxon Hill or items 23a or 28a-f show must be notified at once. MD. Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S.A. 20745 2114 Alice Avenue #2 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral White, etc. Islander If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: Haitian Yes 2X No specify: after Divorced If Yes, Give Year Widowed ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) pleted College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Private traumatic event, the Medical Dentist 4 Com marked other 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) <u>Sonia Lecorps</u> æ Max Gustaye Chaumette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Oakland, CA. 903 WaWona Ave., Yanie Chaumette/Sister If item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State or other Richmond, CA. 2/12/08 Important: I Rolling Hills Mem Other Specify lame and Address of Facility 814 Upshur St. N.W. Tri-State Funeral Services, Inc. 22. Name and Address of Facility ature of Funeral Service License Approximate Interval 3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line. Death fedical a. Hypertensive cardiovascular disease Immediate Cause (Final disease ∡aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical 23a, Pt. II, 27 per ME g877 3/20/08 amh XX UNPENDED AMENDED 1. attending physician for use as the burial The law requires that the death certificate be 23d Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Ectopic pregnancy . Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown g Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 ⋧ Hypothyroidism type II diabetes mellitus 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of death? #11- [OST 1701]7F autopsy performed? has ✓ Yes 2 2 No 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical of Vital Be Other<sub>4</sub> Nursing Home 5 Residence 6 ✔ Other: Scene Hospital: Inpatient 2 ER/Outpatient 3 DDA After this 1 V Yes No Certification: To 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of injury (Month, Day, Year 27. Manner of Death 1 XX Natural Yes 2 No Division Pending within 24 hours after death.

To the Funeral Director: Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be or Town, State) Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wilded Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 1, 2008 O.C.M.E. MA taiho. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Tasha Greenberg MD.

State

Registrar

31. Date filed (Month, Day Year)

2008

distrar's Signature

|                   |   |   | 1 - For<br>State Amend PI line o  | State of Mary<br>25, perME,g877                         | rland / Depa<br>7 3/6/08 <b>උழ</b> | artment of F   | lealth a<br><i>Death</i>      |   | giene<br>Reg. Ne | 08                          | 04487  |  |  |  |  |
|-------------------|---|---|---|---|------------------------------------|--|-------------------------------|---|------------------|-----------------------------|--|--|--|--|--|
|                   |   |   | Decedent's Name (First, Middle, La  |   |                                    |  |                               | 2. Date of De                                 | eath             | V                           | 3. Time of Death                                   |  |  |  |  |
|                   | Physici<br>/Medic   |   | Walter  | Alexander   | Donaldso                           | n  |                               | Januar  | y 28,            | Year<br>2008                | 11:25 A.M  |  |  |  |  |
| ji                | Examir  |   | 4a. Facility Name (If not institution, give   | e street and number)                                    |                                    | 4b. City, Town, o  | r Location of                 | Death   |                  | ty of Death                 |  |  |  |  |  |
|                   | \$ 1 man  |   | Shady Grove Adver   | tist Hospita  | a1                                 | Rockv  |                               |   |                  | ntgome                      |  |  |  |  |  |
|                   | Funeral   |   | 5. Social Security Number 6. S  | Sex 7. Age (In  | yrs. last birthday) Yrs.           | If Under 1 Year<br>Months Days                           | If Under 2<br>Hours           | Min. (Month, Da                               | ay, Year)        | Coui                        |  |  |  |  |  |
| L                 | Director  | Y.  | 177-22-4595 Usual Residence of Decedent   |   | 77 Yrs.                            |  |                               | Feb. 2  | 6, 1930          |                             | PA   |  |  |  |  |
|                   | land<br>ow<br>it  |   | 10a. State 10b. County  | 10  | c. City, Town or Lo                | ocation  |                               |   |                  | 1                           | Od. Inside City Limits                             |  |  |  |  |
|                   | Mary<br>-f sh<br>fied   | to  | Maryland Montgom  | erv   | Rockvi                             | 11e  |                               |   |                  |                             | 1X Yes 2 No  |  |  |  |  |
|                   | r 28a   | Director  | 10e. Street and Number  |   |                                    | 10f. Zip Code  |                               |   | 10g. Citizen of  | f What Cour                 | ntry?  |  |  |  |  |
|                   | th wit<br>23a o<br>ist be   |   | 2304 McAuliffe Dr   | ive   |                                    | 20851  |                               |   | Unit             | ted St                      | ates   |  |  |  |  |
|                   | r dea   | Funeral   | 11. Marital Status  | 12. Was Decedent Ever<br>Armed Forces?                  | r in U.S. 13.                      | Was Decedent of H<br>If Yes, specify Cub                 | lispanic Orig<br>an, Mexican, | in? (Specify Yes or No<br>Puerto Rican, etc.) | D- 14. Ra<br>Bi  | ace - Americ<br>ack, White, |  |  |  |  |  |
| 36                | or It   | by Fu   | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced  | 1⊠Yes 2 No  |                                    | 1 ☐ Yes 2 ☒ No   | Specify:                      |   | Spec             | ify:                        |  |  |  |  |  |
| 21215-0036        | filed within 72 hours after death with the Maryland<br>Hygiene.<br>uther than "natural", or Items 23a or 28a-f show<br>ent, the Medical Examiner must be notified at  | d be  | 15. Decedent's E  | Year or Dates 94  |                                    | dent's Usual Occup                                       | nation                        |   | 16b. Kind of     |                             | nite<br>dustry                                     |  |  |  |  |
| 5                 | in 72<br>n "na<br>Nedic   | Completed   | (Specify only highest gr  | ade completed)  | I (Give                            | kind of work done<br>DO NOT use retire                   | during most                   | of working                                    |                  |                             | ,  |  |  |  |  |
| 212               | with yiene  | E   | Elementary/Secondary (0-12)   | College (1-4or 5+)<br>4                                 |                                    | Analyst  |                               |   | Depart           | ment                        | of Energy  |  |  |  |  |
| פַ                | e filed<br>al Hyg<br>othe<br>vent,  | Be C  | 17. Father's Name (First, Middle, Last  | )   |                                    |  | 18. Mother                    | 's Name (First, Middle                        | , Maiden Surna   | ame)                        |  |  |  |  |  |
| /lar              | uld by<br>Ments<br>Irked  | 70 E  | Robert  | Donaldson   |                                    |  |                               | Penelo  | pe C             | rosby                       |  |  |  |  |  |
| Maryland          | 2 sho<br>and I<br>is ma   | 1 8   | 19a. Informant's Name/Relationship  | Type. Print)  |                                    | ,  |                               | r or Rural Route Numb                         |                  |                             | •  |  |  |  |  |
| ≥, ≤              | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. | V 8   | Carlann D. Czecha   |   |                                    |  |                               | Gaithersbu<br>Date                            | rg, Mar          |                             |  |  |  |  |  |
| Baltimore,        | ges 1<br>It of H<br>If ite<br>or ot   |   | 20a. Method of Disposition<br>1 ☐ Burial 2 KCremation 3 [   | Themoval from State                                     |                                    | osition (Name of<br>ematory or other pla                 |                               |   |                  | •                           |  |  |  |  |  |
| ţ.                | t. Pa<br>rtmer<br>rtant:  |   | 4 ☐ Donation 5 ☐ Other (Speci   |   |                                    |  |                               | 2/1/2008<br>DeVol Fun                         |                  |                             | Virginia   |  |  |  |  |
| Ba                | perm<br>Depa<br>Impo<br>any i   |   | addle of Fulleral Service Lice  | OAlus   | 1 1 1                              |  |                               |   |                  |                             | D. 20877   |  |  |  |  |
|                   |   | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, |   |   |                                    |  |                               |   |                  |                             |  |  |  |  |  |
|                   | Physician   |   | shock, or heart failure. List only<br>Immediate Cause (Final  |   |                                    |  |                               | 0.1   |                  |                             | Approximate<br>Interval Between<br>Onset and Death |  |  |  |  |
|                   | /Medical  |   | disease or condition resulting in death)  | a. Sepsis  Due to (or as a co                           | onsequence of):                    |  |                               | -/-   | Liff             | . 1 1                       | 1105   |  |  |  |  |
| kir.              | Examiner  |   | Coquentially list conditions  | b Wound Infe  | ction                              |  |                               |   | 1.00             | VEM.                        |  |  |  |  |  |
| 165               | P ≒   | Examiner  | Sequentially list conditions, if any, leading to immediate cause. Entire of dentire Cause (Disease or injury that initiated executions) | Due to (or as a co                                      | onsequence of):                    |  | _6                            | \   | /Clive           |                             |  |  |  |  |  |
|                   | ecute<br>and<br>trans   | Kam   | that initiated events resulting in death) Last  | c. Peri heral v   |                                    | sease  | -                             | 1000  | Ment em          |                             |  |  |  |  |  |
| 8760,             | ate be executed hysician and the burial-transit   |   |   | <b>Due to (or as a oc</b>                               | nocquonoo oi).                     |  | CERTIFICA                     | 1. 1. 1/5 b.                                  |                  |                             |  |  |  |  |  |
| 687               |   | dical   |   | _d  |                                    |  |                               | 1   |                  | 1                           |  |  |  |  |  |
| Box (             | certif<br>nding<br>use a  | Z/M   | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome pf p                               |                                    |  |                               | Y   | 23d. E           | Date of deliv               | rery   |  |  |  |  |
|                   | death<br>atter  | icia  | in the past 12 months? 1 □ Yes 2 □ No   | 1□Live birth 2□<br>4□Pregnant at tim                    |                                    | ⊒Ectopic pregnanc<br>⊒ Other <i>(sp</i> ec <i>ify)</i> _ | y .                           | <u>'</u>                                      | 1                | Month                       | Day Year   |  |  |  |  |
| 0                 | t the by the  | Physician/Me  | 9 □ Unknown   | 9∐ Unknown  |                                    |  |                               | 17  |                  |                             |  |  |  |  |  |
| S,<br>D           | w requires that the death certific<br>been signed by the attending p<br>should be detached for use as   | by P  | Part II. Other significant conditions   | contributing to death but no                            | ot resulting in the u              | anderlying cause giv                                     | ven in Part I.                |   |                  |                             | the cause of death?                                |  |  |  |  |
| or Vital Records, | equire<br>en siç<br>ould b  | pel   |   |   |                                    |  |                               | 1   | Yes 2 No         | 3 □ Pro                     | bably 4 🖾 Unknown                                  |  |  |  |  |
| ecc               | aw<br>s b   | Completed   |   |   |                                    |  |                               | 24a. Was                                      | s an 24          | b. Were aut<br>prior to co  | opsy findings available ompletion of cause of      |  |  |  |  |
| =<br>E            |   | Som   |   |   |                                    |  |                               | peri<br>1□ Yes                                | formed?<br>2⊠ No | death?                      | 2 □ No   |  |  |  |  |
| /ita              | sician: The la<br>certificate ha<br>irector, page 2   | Be (  | 25. Was case referred to medical examiner?  | Licental.   |                                    | Tou  |                               | of Death (Check only                          | one)             |                             |  |  |  |  |  |
| Or.               | Physical this call dire   | 은   | 1 Yes 22 No   | Hospital: 1X Inpatient                                  | <del></del>                        | 111 O D D D D D D D D D D D D D D D D D                  |                               | rsing Home 5 Res                              |                  |                             | ify)   |  |  |  |  |
| on C              | Jing F<br>After<br>funer  | ion:  | 27. Manner of Death  1 ☑ Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Ye                   | ear) 28b. Time o<br>Injury         | Wo   | nyaτ<br>rk?<br>]Yes 2∐1       |   | how injury occ   | urrea                       |  |  |  |  |  |
| Division          | death<br>death<br>ctor:<br>y the  | licat   | 2 Accident investigation 3 Suicide 6 Could not be   | e 28e Place of injuny                                   | At home, farm, st                  |  |                               |   | (Street and Nui  | mber or Rui                 | ral Route Number,                                  |  |  |  |  |
| Ω̈́               | after after I Dire  | Certification:  | 4 ☐ Homicide determined   | building, etc. (5                                       | Specify)                           |  |                               | City or To                                    | own, State)      |                             |  |  |  |  |  |
|                   | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,  |   |   | hysician: To the best of m<br>miner: On the basis of ex |                                    |  |                               |   |                  |                             |  |  |  |  |  |
|                   | the Ho<br>in 24<br>the Fu   | Medical   | one)  | and manner stated                                       |                                    | nvestigation, in my                                      | opinion, dea                  | th occurred at the time                       | e, date and plac | e, and due                  | to the cause(s)                                    |  |  |  |  |
|                   | To To   | Σ   | 29b. Signature and title of certifier   |   | ,                                  | 29c. Licen:  |                               | 6.170   | 29d. Date sig    | ned (Month                  | , Day, Year)                                       |  |  |  |  |
| )                 |   |   | ) a   | VI  | <u></u>                            |  | 00 G                          | 1475  | Januar           | ry 29,                      | 2008   |  |  |  |  |
|                   |   |   | 30. Name and address of person who  |   |                                    |  | dero D                        | onlessed 11 o                                 | Marvile          | nd 209                      | 850  |  |  |  |  |
|                   | C+  | ate   | Sanaei Ardekani,  | M.D., 9901 N  | Cianature                          | -  | rve, K                        | OCKVIIIe,                                     | riai y Lai       | .iu 200                     | ,,,,,  |  |  |  |  |
|                   | - Domint  | ate.  |   | 008   | KA                                 | cache)   |                               |   |                  |                             |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Year ahvery 1018 M Gludys 1 Louise, Davis 3008 /Medical 28 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shudy RUCKVille Grove 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🗹 F Days Hours Min. Country) 220-58-6762 79 Director Aug.23,1928 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f shov notified at MD Poolesville 1 Yes 2 No Director Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ?7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 20837 18530 Jerusalem Church Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Montgomery Co. Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Is marked other than Public Schools Teachers Aid 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Mary Plummer Henry Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cigi Oakley (Daughter) 6181 Villa Flora, Bonsall, CA other t 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Department of h
Important: If Ite
any injury or ot
once. 1 ☑ Burial 2 □ Cremation 3 □ Removal from State ilah Church Cem 2/2/08 Poolesville,MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Licks 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. to not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician OUAR.m cance disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine that the death certificate be executed and the burial-trag resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician for use as the buris Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. certificate has been signed by the irector, page 2 should be detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an perform 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 1 ☐ Yes 2 ☐ No Certification: To 1. Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? al or Attending Paffer death.
I Director: Affer to in by the funers 28d. Describe how injury occurred 12 Natural (Month, Day Year) 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) 035635

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of pe

31. Date filed (Month, Day,

Phile DR.

rson who completed cause of death (Item 23a) (Type Print)

18111 Prince

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** DEPALMA JOSEPH Oi 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Bournoris incoldsing of maly cans med. ch CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | FEB . 3 , 1923 5. Social Security Number 9. Birthplace (State or Foreign Country) Pennsylvania 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 XM 2 □ F 84 175-14-7868 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h. County 10d. Inside City Limits 28a-f show must be notified 1 ☐ Yes 2 X No Director Maryland Frederick Frederick the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filled within 72 hours after death with and Mental Hygiene.

is marked other than "natural", or Items 23a or 6747 Meadowside Drive 21702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-li Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status r than "natural", or Iten the Medical Examiner Black, White, etc. 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2 X No Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) U.S. Government Elementary/Secondary (0-12) College (1-4or 5+) Engineering Architectural Consultant traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph DePalma Alberta Bricker မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau 6747 Meadowside Dr./ Frederick, Maryland 21702 Dorothy DePalma / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion UMC Cem. 02/01/2008 |Myersville,Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702 unt 23a. Rart1. Enter the disease, or shock, or heart failure. List complications that cays of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Pulmonthy FAILURE Immediate Cause (Final SPAE FRATURE Physician days 22 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner enatom RETRO per Tone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine WEXAMINER be executed as the burial-tran Due to (or as a consequence of) attending physician Physician/Medical PATIFIC IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t After t 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural M/mommun 1 ☐ Yes 2 No RIGHT SING 2 Accident 01 06 208 FUL ON the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Frencisk, 40 6747 MAMONSIDE 21702 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) To the

Baltimore, Maryland 21215-0036

Box 68760,

P.O. I

Division or Vital Records,

State Registrar 29b. Signature and title of certifier

FEB 0

Dunguis L

Bervet 22 5 Cretar STREET 31. Date filed (Month, Day, Year) 32. Begistrar's Signature 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

2

Brimone did

29d. Date signed (Month. Dav. Year)

21201

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Lillian Ruth Dowdy 01/31/2008 2:45 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert County Nursing Center Prince Frederick Calvert 8. Date of Birth (Month, Day, Year) 07/12/1926 5. Social Security Number 6 Sev If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 X I 82 Director 578-32-8095 Wash. D.C Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show at be notified 1 ☐ Yes 2X No Director MD Calvert Huntingtown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō "natural", or items 23a 5118 Coach Court 20639 must ! U.S.A. Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Examiner 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: δ 3 X Widowed 4 ☐ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Loan Officer Credit Union 1 and 2 should be filed w Health and Mental Hygier em 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Camillus Edward Wood Lillian May Daniels 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra June Fisher - Daughter 5120 Coach Ct. Huntingtown MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lee Crematory 02/01/2008 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Md Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner MON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off certificate be executed End tug and burial-trai Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2至 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate | 1∐ Yes 2 🗆 No 27 1 Yes 25. Was case referred to medical examiner? director Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 → No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending To the Hosp..... within 24 hours after dea... To the Funeral Director: Aftr 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

MD 110 Hospital Road, Suite 310 Prince Frederick, MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registra

s Signature

Jonathan Lowenthal,

FEB

31. Date filed (Month, Day, Year)

|                     |  |                     | For<br>State<br>Registrar   | State of Ma  | •                                 | epartment of<br>Certificate of                                       |                              | , ,                              | glene<br>eg. No. 🤈 🎧 🦳 🤇                | 0 01.1.01  |
|---------------------|--|---------------------|---|--|-----------------------------------|--|------------------------------|----------------------------------|---|--|
|                     | Physicia   | 20                  | 1. Decedent's Name (First, Middle, Last)  |  |                                   |  |                              | 2. Date of Dea                   | th 2000                                 | 3. Time of Death                                 |
|                     | /Medic   | al                  | Byron Goode   |  | r.                                |  | A Contract                   |                                  | y 31, 2008                              | 7:30 A <sup>M</sup>                              |
|                     | Examin   | er                  | 4a. Facility Name (If not institution, give s<br>4530 Mattapany Roa   |  |                                   | 4b. City, Town,  | or Location of Death         |                                  | 4c. County of Dea                       | ith  |
| -                   | Funeral  | ×                   | Social Security Number 6. Sex   | 7. Age   | (In yrs. last birth               | nday) If Under 1 Year  | If Under 24 Hrs.             | 8. Date of Birth                 |   | thplace (State or Foreign                        |
|                     | Director   | d.                  | 233-32-1720   | M 2□F  | 84 Y                              | rs. Months Days  | Hours Min.                   | May 13, 1                        | 1924 Wes                                | t Virginia                                       |
|                     | and<br>w   |                     | Usual Residence of Decedent  10a. State 10b. Counfy   |  | 10c. City, Town                   | or Location  |                              |                                  |   | 10d. Inside City Limits                          |
|                     | Maryl<br>I-f sho   | tor                 | Maryland Calvert  |  | St. Lean                          | ard  |                              |                                  |   | 1 □Yes 2 🛣 No                                    |
|                     | th the<br>or 28a<br>e noti   | Jirec               | 10e. Street and Number  |  |                                   | 10f. Zip Code  |                              | 1                                | 0g. Citizen of What C                   | -  |
|                     | ath wi   | ral                 | 4530 Mattapany Road   |  |                                   | 20685  |                              |                                  | United State                            |  |
| 36                  | should be filed within 72 hours after death with the Maryland<br>nd Mental Hygiene.<br>marked other than "natural", or Items 23a or 28a-f show<br>imatic event, the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced   | <ol> <li>Was Decedent E<br/>Armed Forces?</li> <li>1X Yes 2 N<br/>If Yes, Give<br/>Year or Dates: 1</li> </ol> | o                                 | 13. Was Decedent of<br>If Yes, specify Cu<br>1 ☐ Yes 2 X No          |                              | Rican, etc.)                     | Black, Whi                              |  |
| Maryland 21215-0036 | 2 hour<br>atural<br>cal Ex   | ted t               | 15. Decedent's Educ   | ation  | 16a. I                            | Decedent's Usuai Occu  | pation                       |                                  | 16b. Kind of Business                   | /Industry  |
| 215                 | thin 72<br>e.<br>an "n   | Completed           | (Specify only highest grade<br>Elementary/Secondary (0-12)  | College (1-4or 5-  | -)                                | (Give kind of work done<br>life. DO NOT use retin                    | e during most of worl<br>ed) | king                             |   |  |
| 2                   | led wi   | Con                 | 12 17. Father's Name ( <i>First, Middle, Last</i> )   | 1  |                                   | Electrician  | 19 Mothor's Nom              | o /First Middle                  | Metal Manufa<br>Maiden Surname)         | cturing  |
| ano                 | d be fi  | Be C                | Byron Goode Doom,   | Sr.  |                                   |  |                              | et Mille                         | ,                                       |  |
| 37                  | d 2 should<br>th and Men<br>7 is marke<br>traumatic  | To                  | 19a. Informant's Name/Relationship (Type  |  | 19b.                              | Mailing Address (Stree   |                              |                                  |   | Zip Code)  |
|                     | 1 and 2<br>Health a<br>em 27 is  |                     | Betty Lucas Doom /  | Wife   |                                   | 30 Mattapar  | ny Rd., St                   |                                  |   |  |
| Baltimore,          | permit. Pages 1 and<br>Department of Health<br>Important: If Item 27<br>any Injury or other tr   |                     | 20a. Method of Disposition  1 □ Bunal 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)                                       | emoval from State  | 20b. Place of cemetery  Cauley Br | Disposition (Name of<br>crematory or other plants.)<br>Cidge Baptist | ace) 02/03                   |                                  | 20c. Location - City of<br>Suley Bridge | , West Virginia                                  |
| Salti               | epartruporta   |                     | 21. Signature of Funeral Service License  | M.   | $\wedge$                          |  |                              |                                  | neral Home,                             |  |
|                     | ⊙ □ ≒ @ O  |                     | Mechael Teva  | Heicher,   | the death Do no                   |  |                              |                                  | t Republic                              | Approximate                                      |
|                     | Physician  |                     | 23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition         |  |                                   | OF DEA   |                              | or respiratory are               |   | Interval Between<br>Onset and Death              |
|                     | /Medical<br>Examiner   |                     | resulting in death)   |  | consequence o                     |  |                              |                                  |   |  |
| *                   |  | er                  | Sequentially list conditions, if any, leading to immediate  | Due to (or as a  | consequence of                    | f):  |                              |                                  |   |  |
|                     | cuted<br>id<br>ransit  | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |  |                                   |  |                              |                                  |   |  |
| Ö,                  | e exe  | l Ex                | resulting in death) Last  | Due to (or as a  | consequence of                    | f):  |                              |                                  |   |  |
| 68760,              | ificate be executed<br>g physician and<br>as the burial-transit  | edical              | d   |  |                                   |  |                              |                                  |   |  |
| O. Box 6            | The law requires that the death certificate has been signed by the attending page 2 should be detached for use as  | Physician/Me        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 3c. If yes, outcome p<br>1□Live birth<br>4□Pregnant at<br>9□Unknown  | 2 🗌 Fetal death                   | 3□Ectopic pregnan<br>5□ Other (specify)                              | су                           |                                  | 23d. Date of de<br>Month                | elivery<br>Day Year                              |
| 1                   | signed by  |                     | Part II. Other significant conditions con   | tributing to death bu  | t not resulting in                | the underlying cause g   | iven in Part I.              | 23e. Did to                      | bacco use contribute                    | to the cause of death?                           |
| rds                 | w requires<br>been sign<br>should be   | ed by               | CORONARY AR   | TEAT   | DISTAJE                           |  |                              | 1 □ Y                            | es 2⊡Ho 3∏F                             | robably 4 Unknown                                |
| Vital Records,      | sician: The law re<br>certificate has ber<br>irector, page 2 sho   | Completed           | PREVIOUS ST   | ROKE   |                                   |  |                              | 24a. Was a autops perfor         | med?   death?                           | utopsy findings available completion of cause of |
| T<br>T              |  | Be C                | 25. Was case referred to medical examiner?  |  |                                   |  | 26. Place of Dea             |                                  |   |  |
|                     | > 00 00  | 70                  | 1 ☐ Yes 2 ☐ Mo  |  |                                   | patient 3 DOA  |                              |                                  | ence 6 Other (Sp                        | ec <i>ify</i> )                                  |
| u                   | ding Ph<br>h.<br>After thi<br>funeral  | ion:                | 27. Manner of Death  1 ☐ Matural 5 ☐ Pending  2 ☐ Accident investigation  | 28a. Date of Injur<br>(Month, Day  |                                   | jury W   | uryat<br>ork?<br>⊒Yes 2 □ No | 28d. Describe no                 | ow injury occurred                      |  |
| Division or         | r Attenter death   | Certification:      | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined   | 28e. Place of inju<br>building, etc  | ry - At home, fari<br>. (Specify) | m, street, factory, office   |                              | 28f. Location (S<br>City or Town | treet and Number or F<br>n, State)      | Rural Route Number,                              |
|                     | To the Hospital of within 24 hours aft To the Funeral D completely filled in   | Medical C           |   |  | examination and                   | death occurred at the<br>for investigation, in my                    |                              |                                  |   |  |
|                     | To th<br>within<br>To th<br>comp   | Me                  | 29b. Signature and title of certifier   | , 1)   |                                   | 29c. Licer   | ise number                   | 2                                | 29d. Date signed (Mor                   | oth, Day, Year)                                  |
| }                   |  |                     | 1 (h + 9)   | egg m  | 6                                 | 02   | 6358                         |                                  | JAN.31.                                 | 2008   |
| ١.                  | , <u>-</u>   |                     | 30. Name and address of person who co   |  | _                                 |  |                              |                                  |   |  |
| R                   | N 5<br>Sta   | te                  | 31. Date filed (Month, Day, Year)   | 32. Registra   | Signature                         | ans- fr  | ع ع سوا ع                    | 1-12 F.3                         | The Kind                                | 77)-20678  |
|                     | Registr  |                     |   | 1 2008   | Engane 1                          | & South  | j.                           |                                  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Joan Harding Dankewicz /Medical January 2008 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country)

VA 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 ☐ M 2 🖺 F Hours 74 212-32-8892 Director Nov. 16, 1933 Usual Residence of Decedent 10a, State 10c. City, Town or Location Show 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director Anne Arundel Glen Burnie 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1343 Aster Drive 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 212 No Specify. White þ Specify: 3 Nidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Counseling Center Administrative Assistant 12 and Mental Hygi Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emerson Otha Harding Naomi Whittaker or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra Eric Eugene Dankewicz/Son 884 Willys Drive, Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb. 2, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 2008 Barranco & Sons, P.A. Severna Park Funeral Ho 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Furgeral Service Licenses Part 1. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** Cancer Unknown month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on certificate be executed siclan and burial-trans Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed certificate 2/No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: completely filled in by the 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier

Division or Vital Records, P.O. Box 68760, the Hospital or Attending within 24 hours a

> State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifie

ronnel Cohen ML

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

and manner stated.

5701 N. Charles Street Bullimore MN 21204

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Betty May Disney 01/27/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospice of the Chesapeake Harwood Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Securify Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 □ M 12/12/F 79 Director 579-28-1440 June 12, 1928 Washington, D.C. Usual Residence of Decedent with the Maryland a or 28a-f show t be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 XX o Maryland | Anne Arundel Shady Side 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a 1216 Pine Avenue 20764 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a any inJury or other traumatic event, the Medical Examiner must once. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 D No If Yes, Give Year or Dates; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXXVo Specify þ Specify: U.S.A. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> <u>Own Home</u> 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Wilbur Beall Charlsie Denton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Disney/ Husband 1216 Pine Avenue, Shady Side, Maryland 20764 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Maryland Veterans Cemetery 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 02/01/2008 Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician HORNO COVCINONE months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician Physician/Medical the signed by the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Day Month Year 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> page 2 should it 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate 10 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: $4 \square \text{ Nursing Home}$ $5 \square \text{ Residence}$ $6 \cancel{X} \text{Other (Specify)} \text{ Hospice}$ 1 ☐ Yes 2 ☐ ပ 1 🗌 inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 2 ☐ Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

P.O. Box 68760, Division or Vital Records,

Baltimore, Maryland 21215-0036

Medical Registrar

State

29a. Certifier

(Check only

29b. Signature and title of certifier

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Canine

32/Registrans Šignatur 31. Date filed (Month, Day, Year) **JAN 3 1** 2008

|                            |  |                    | For<br>State   |                                   | State                                | of Ma                    | aryland /                        | •                 | ertment of   |                 |  | Men                 | •                         | 0                       | 000                                      | 01101  |
|----------------------------|--|--------------------|--|-----------------------------------|--------------------------------------|--------------------------|----------------------------------|-------------------|--|-----------------|--|---------------------|---------------------------|-------------------------|--|--|
|                            |  |                    | Registrar     Decedent's Name  | e (First, Middle, I               | Last)                                |                          |                                  | Cei               | inicate of   | De              | aui  |                     | ate of Dea                |                         | UUB                                      | 3. Time of Death                                   |
| 3.                         | Physici<br>/Medic  |                    | Edna   | a V. Diz                          | e                                    |                          |                                  |                   |  |                 |  | 2                   | onth 2                    | Day                     | ĎB                                       | 7:35AM   |
|                            | Examin   | A 45               | 4a. Facility Name (III   | not institution, g                | give street and r                    | number)                  | Lake                             |                   | 4b. City, Town,  | or Loc          | sation of Dear                                   | th<br>U/ \/         | 1                         | 4c. Co                  | unty of Death                            | comico   |
|                            | Funeral<br>Director  |                    | 5. Social Security N 221-09-48   | 1                                 | . Sex<br>1 □ M 2 2 4 F               |                          | e (In yrs. last I                | oirthday)<br>Yrs. | If Under 1 Yea<br>Months Days                          |                 | Under 24 Hrs<br>lours Min                        | . (/                | ate of Birt<br>Month, Day | h<br>y, Year)<br>3,1908 | Coul                                     | place (State or Foreign<br>ntry)<br>yland          |
|                            | pui *  |                    | Usual Residence of<br>10a, State   | Decedent<br>10b. County           |                                      | _                        | 10c. City, To                    | wn or Lo          | cation   |                 |  |                     |                           |                         |  | 10d. Inside City Limits                            |
|                            | death with the Maryland<br>ims 23a or 28a-f show<br>r must be notified at  | ě                  | DE   | Suss                              | OV                                   |                          | De1                              |                   |  |                 |  |                     |                           |                         |  | 1 □ Yes 2 🖾 No                                     |
|                            | r 28a-   | irec               | 10e. Street and Nur  |                                   | CA                                   |                          | ВСТ                              | ma L              | 10f. Zip Code  | -               |  |                     |                           | 10g. Citizer            | of What Coul                             | ntry?  |
|                            | th wit   | a D                | 5045 Wh:   | ite Deer                          | Road                                 |                          |                                  |                   | 19940  |                 |  |                     |                           | U.S                     |  |  |
| 36                         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | y Funeral Director | 11. Marital Status  1 ☐ Never Marri 3 ☑ Widowed  |                                   | Armed                                | Forces?<br>s 2⊠N<br>Give | Ever in U.S.<br>No               |                   | Vas Decedent of<br>f Yes, specify Cu<br>I □ Yes 2【X No |                 | inic Origin? (<br>Nexican, Pue<br><i>pecify:</i> | Specify<br>no Ricar | Yes or No<br>n, etc.)     |                         | Race - Americ<br>Black, White,<br>ecify: |  |
| 5-0036                     | tural  | Completed by       |  | 15. Decedent's                    | Education                            |                          | 16                               | a. Deced          | lent's Usual Occi                                      | upation         | n  |                     |                           | 16b. Kind               | of Business/In                           | dustry   |
| 215                        | hin 72<br>9.<br>an "na<br>Medik  | plet               | (Speci   | ify only highest                  | grade complete                       | d)<br>(1-4or 5           | i+)                              | (Give<br>life. L  | kind of work don<br>OO NOT use retir                   | e durir<br>red) | ng most of wo                                    | orking              |                           |                         |  |  |
| 2121                       | ed wit<br>ygien<br>ygien<br>her tha<br>t, the  | 5                  | 8  |                                   |                                      | `                        |                                  | Seam              | stress   | 1               |  |                     |                           |                         | ent Fac                                  | ctory  |
| 17 and                     | ntal Hi<br>ed oth  | To Be              | 17. Father's Name  |                                   | ·                                    |                          |                                  |                   |  |                 | . Mother's Na<br>Mary K                          |                     |                           | Maiden Su               | rname)                                   |  |
|                            | should<br>nd Me<br>mark<br>matic   | 유                  | George V   |                                   |                                      |                          | 11                               | 9b. Mailin        | ng Address (Stree                                      |                 |  |                     |                           | er, City or To          | own, State, Zip                          | o Code)  |
| y                          | nd 2 salth ar 27 is r trau   |                    | April Th   |                                   |                                      | laugh                    | nter) 5                          | 045               | White De   | eer             | Rd.  | Delm                | nar,                      | DE 19                   | 9940                                     |  |
| Edna Diz                   | ages 1 a<br>ant of Hea<br>t: If Item<br>y or othe  |                    |  | osition  Cremation 3 5 Other (Spe |                                      | m State                  | ceme                             | tery, crer        | sition (Name of<br>matory or other p                   |                 |  | Date . 6 ,          | 2008                      |                         | ion - City or T                          |  |
| / <u>7</u> ) ≝             | mit. Partme  | 1                  | 21. Signature of Fu  |                                   |                                      |                          | phrin                            | 22                | Memory  Name and Add                                   | ress o          | f Facility                                       |                     |                           | перто                   | n, Hat                                   | ylanu  |
| W.                         | permi<br>Depar<br>Impor<br>any ir  |                    | M.C  | Tweek                             | 1                                    |                          |                                  |                   | hort Fu  |                 |  |                     |                           | r, DE                   | 19940                                    | )  |
|                            |  |                    |  | rt failure. List or               | mplic tions than<br>nly one cause or | it caused<br>n each lir  | the death. D                     | o not ent         | er the mode of d                                       | ying, s         | such as cardia                                   | ac or res           | piratory a                | rrest,                  |  | Approximate<br>Interval Between<br>Onset and Death |
|                            | Physician  |                    | Immediate Cause (<br>disease or conditio<br>resulting in death)                          | Final<br>n                        |                                      |                          |                                  |                   | CULA   | 2               |  | 400                 | -13 R                     | NT                      |  |  |
|                            | /Medical<br>Examiner   |                    | ,  | 1                                 | Due                                  | to (or as                | a consequenc                     | e of):            |  |                 |  |                     |                           |                         |  |  |
|                            |  | Je.                | Sequentially list co<br>if any, leading to in<br>cause. Enter Under<br>Cause (Disease or | nditions,<br>nmediate             | b. — Due                             | to (or as                | a consequenc                     | e of):            |  |                 |  |                     |                           |                         |  |  |
|                            | be executed<br>sician and<br>burial-transit  | Examiner           | mai initialed events   |                                   | c                                    |                          |                                  |                   |  |                 |  |                     |                           |                         | ill.                                     |  |
| 8760,                      | ate be exe<br>hysician al<br>he burial-l   |                    | resulting in death) I  | _ast                              | Due                                  | to (or as                | a consequenc                     | e of):            |  |                 |  |                     |                           |                         |  |  |
| 876                        | physic<br>the b  | dical              |  |                                   | d                                    |                          |                                  |                   |  |                 |  |                     |                           | <del>.</del>            |  |  |
| Box 6                      | leath certifica<br>attending ph<br>I for use as th   | //Me               | IF FEMALE:<br>23b. Was deceden   | t pregnant                        |                                      |                          | pf pregnancy                     |                   |  |                 |  |                     |                           | 230                     | . Date of deliv                          | rery   |
| .O. Be                     | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit   | Physician/Med      | in the past 12<br>1 Yes 25   | months?                           | 4□Pre                                |                          | 2 □ Fetal dea<br>t time of death |                   | Ectopic pregnar Other (specify)                        |                 |  |                     |                           |                         | Month                                    | Day Year   |
| <u> </u>                   | uires that the de<br>signed by the a<br>d be detached f  | , Ph               | Part II. Other signif  |                                   | s contributing to                    | death b                  | ut not resulting                 | in the u          | nderlying cause o                                      | jiven ir        | n Part I.  |                     | 23e. Did t                | obacco use              | contribute to                            | the cause of death?                                |
| rds                        | quires<br>n sign<br>ald be   | d by               |  |                                   |                                      |                          |                                  |                   |  |                 |  |                     | 1 🗆 '                     | Yes 2                   | ¶o 3□Pro                                 | bably 4 □Unknown                                   |
| 000                        | aw requires<br>s been si<br>2 should b   | Completed          |  |                                   |                                      |                          |                                  |                   |  |                 |  |                     | 24a. Was                  |                         | 24b. Were aut                            | opsy findings available                            |
| Ä                          | The lav  | E O                |  |                                   |                                      |                          |                                  |                   |  |                 |  |                     | autoj<br>perfo<br>1∐ Yes  | rmed?                   | death?<br>1 ☐ Yes                        | ompletion of cause of                              |
| /ita                       | yslcian: Th<br>is certificate<br>director, pag   | Be (               | 25. Was case refer examiner?   | red to medical                    | I be existed.                        |                          |                                  |                   |  |                 | 6. Place of De                                   | eath (Ch            | eck only o                | ne)                     |  |  |
| or \                       | Physic<br>this o   | ဥ                  | 1 Yes 27. Manner of Deat   |                                   |                                      | hpatie                   |                                  | Outpatier         | IL 3 DOA   |                 |  | _                   |                           | dence 6 D               | Other (Speci                             | ify)   |
| on                         | Attending Physician: ir death. ector: After this certifica by the funeral director. I  | tion               | Natural 2 Accident   | 5 ☐ Pending investiga             | (M                                   | lonth, Da                | y Year)                          | Injury            | W  |                 | 2 No   | 200.                | Describe                  | now injury o            | coarred                                  |  |
| Division or Vital Records, | Atter  | Certification:     | 3 ☐ Suicide<br>4 ☐ Homicide  | 6 Could no determin               | 200. FIG                             | ace of injuding          | ury - At home,<br>c. (Specify)   | farm, str         | eet, factory, offic                                    | е               |  |                     | ocation (                 |                         | lumber or Rui                            | al Route Number,                                   |
| Ö                          | talors afte al Dire  | Cert               | 4Tiomicide   | 12                                |                                      | ilding, et               | c. (Specify)                     |                   |  |                 |  |                     | only of Tol               | wn, State)              |  |  |
|                            | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director; A<br>completely filled in by the fu   | Medical            | 29a. Certifier<br>(Check only<br>one)  |                                   | xaminer: On the                      |                          | f examination                    |                   | h occurred at the<br>vestigation, in m                 |                 |  |                     |                           |                         |  |  |
|                            | To the within 2 To the complet   | Me                 | 29b. Signature and   | title of certifier                |                                      |                          | -                                |                   | 29c. Lice  |                 |  |                     |                           |                         | igned (Month                             |  |
|                            | ( )  |                    | 1  | 5                                 | 6                                    |                          |                                  |                   | Do   | 05              | 74   | 10                  |                           | 2                       | 11/0                                     | 8  |
|                            | 3ty  |                    | 30. Name and add   | ress of person w                  | ho completed ca                      | ause of d                | leath (Item 23a                  | a) (Type,         | Print)   | 0.0             | 2  |                     | -                         | C 4 . *                 |  |  |
|                            | Sta  | nte.               | 31. Date filed (Mon  | th, Day, Year)                    | KY Cl                                | Redistr                  | rar's Signature                  | rosp              | ich  | 0.              | 130 X  | 173                 | 5 -                       | THUS                    | augy                                     | 8 mp 21801   |
|                            | Regist   |                    |  |                                   | 2008                                 | A CAS                    | me /                             | 1 1               | hart.  |                 |  |                     |                           |                         |  |  |

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Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: completely filled in by the funeral director, within 24 hours a To the Funeral I

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c, License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

036576

RIVERSIDE DR SHLIS

29d. Date signed (Month, Day, Year)

I RAWIRE MD KONALD

gistrar's Signature

Descritiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

002

31. Date filed (Month, Day, Year) State Registrar

29a, Certifier

Medical

FEB 0 1 2008

|                            |   |                               | For State Registrar   |                                   | aryland / D                 | epartment of Health  Certificate of Deal                                     | n and Mental H  | ygiene                            | 008                               | 04496   |  |  |  |
|----------------------------|---|-------------------------------|---|-----------------------------------|-----------------------------|--|---|-----------------------------------|-----------------------------------|---|--|--|--|
|                            |   |                               | Registrar  1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death   |                                   |                             |  |   |                                   |                                   |   |  |  |  |
|                            | Physic  | ian                           |   |                                   | orth                        |  | Month   | Day                               | Year                              |   |  |  |  |
|                            | /Medi   |                               |   |                                   | OL LII                      |  | Januar  | 1                                 | 2008                              | 6:00 A M                                      |  |  |  |
|                            | Examir  | ner                           | 4a. Facility Name (If not institution, gi   |                                   | 1 1,                        | 4b. City, Town, or Location  |   |                                   | ounty of Death                    |   |  |  |  |
|                            |   |                               |   | e At the                          |                             | Salisbur   |   |                                   | Wicomico                          |   |  |  |  |
|                            | Funeral   |                               |   | Month                             |                             |  | If Under 1 Year If Under 24 Hrs. 8, Date of E<br>Months Days Hours Min. (Month, I |                                   |                                   | lace (State or Foreign                        |  |  |  |
|                            | Director  |                               | 217-20-2045   |                                   | 79 Y                        | rs.  | 1/29  | /1929                             |                                   | ryland  |  |  |  |
|                            | pug *   |                               | Usual Residence of Decedent  10a. State 10b. County   |                                   | 10c. City, Town             | or Location  |   |                                   |                                   | 0d. Inside City Limits                        |  |  |  |
|                            | arylé<br>sho  | 5                             |   |                                   |                             | "  | 1 TaYes 2 ☐ No  |                                   |                                   |   |  |  |  |
|                            | 98 -1-88  | Sc                            | Maryland Wicom  | CO                                | Salisk                      |  |   | <del></del>                       |                                   | -   |  |  |  |
|                            | death with the Maryland<br>ms 23a or 28a-1 show<br>rimust be notified at  | 2                             | 10e. Street and Number  | 220                               |                             | 10f. Zip Code<br>21801   |   |                                   | n of What Coun<br>תב              | itry?   |  |  |  |
|                            | 23°   | Completed by Funeral Director | 600 Tony Tank Lane  |                                   |                             | 21001  |   | USA                               |                                   |   |  |  |  |
|                            | ep .  | Ine                           | 11. Marital Status  | 12. Was Decedent Armed Forces?    | Ever in U.S.                | <ol> <li>Was Decedent of Hispanic<br/>If Yes, specify Cuban, Mexi</li> </ol> | Origin? (Specify Yes or fi  | No- 14.                           | Race - America<br>Black, White, e |   |  |  |  |
| £ 8                        | or ite  | Ē                             | 1 Never Married 2 Married   | 1 ☐ Yes 2 🟋                       | No                          | 1 ☐ Yes 2 ☒ No Spec  |   |                                   |                                   |   |  |  |  |
| 21215-0036                 | 72 hours<br>natural',<br>deal Exe   | Q P                           | 3 X Widowed 4 □ Divorced  | Year or Dates:                    |                             |  |   | 3,                                | will                              | white   |  |  |  |
| S 7                        | 72 h  | ete                           | 15. Decedent's E<br>(Specify only highest gi  | ducation<br>ade completed)        | 16a. [                      | Decedent's Usual Occupation Give kind of work done during it                 | nost of working   | 16b. Kind                         | of Business/Ind                   | dustry  |  |  |  |
| _2 <b>K</b>                | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatilt and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified at once. | du                            | Elementary/Secondary (0-12) College (1-4or 5+)  |                                   |                             | Give kind of work done during a<br>life. DO NOT use retired)                 | · · · · · · · · · · · · · · · · · · ·   |                                   |                                   |   |  |  |  |
|                            |   | Ö                             | 12  | 2                                 |                             | wner   |   | jewelry                           |                                   |   |  |  |  |
| D D                        |   | Be                            | 17. Father's Name (First, Middle, Las   |                                   |                             |  |   | ne (First, Middle, Maiden Sumame) |                                   |   |  |  |  |
| $\leq \frac{8}{a}$         |   | 10                            | Russell Powell V  | White                             |                             | M  | arie Davis  |                                   |                                   |   |  |  |  |
|                            |   |                               | 19a. Informant's Name/Relationship Julie D. Brewind   |                                   |                             | Mailing Address (Street and Nur<br>175 Meadow Brid                           |   |                                   |                                   |   |  |  |  |
| - 0                        |   |                               |   | geom adagne                       | 10121                       |  |   |                                   |                                   |   |  |  |  |
| o o                        | To the  |                               | 20a. Method of Disposition  1 DBurial 2 Cremation 3 [   | ☐Removal from State               | cemetery                    | Disposition (Name of crematory or other place)                               | Date  | 20c. Locat                        | tion - City or To                 | wn, State                                     |  |  |  |
| <b>₹</b> .≣                | men<br>tant:<br>jury  |                               | `4 □ Donation 5 □ Other (Special  |                                   | Parsons                     |  | 2/1/08  |                                   | bury, N                           |   |  |  |  |
| Katherine<br>Baltimore, Ma | Departr<br>Departr<br>Importa<br>any inju   |                               | 21. Signature of Funeral Service Lice   | rispe                             | 200                         | 22 Name and Address of Fa<br>HOLLOWAY Fund                                   | eral Home Pr  | ofessi                            | onal As                           | sociation                                     |  |  |  |
|                            | 40240   |                               | Mould ( Allissey ( ) 501 Snow Hill Rd., Salisbury, MD 21804   |                                   |                             |  |   |                                   |                                   |   |  |  |  |
| _                          |   | 7                             | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between   |                                   |                             |  |   |                                   |                                   |   |  |  |  |
|                            | Physician   |                               | Immediate Cause (Final disease or condition resulting in death)  a. Non-Hodgkins Lymphoma   |                                   |                             |  |   |                                   |                                   |   |  |  |  |
|                            | /Medical  |                               | resulting in death)  Due to (or as a consequence of):   |                                   |                             |  |   |                                   |                                   |   |  |  |  |
|                            | Examiner  |                               | Conventially list conditions  | b                                 |                             |  |   |                                   |                                   |   |  |  |  |
|                            | n =   | ner                           | if any, leading to intriediate cause. Enter Underlying  | Due to (or as                     | a consequence of            | ).   |   |                                   |                                   |   |  |  |  |
|                            | te be executed<br>ysician and<br>e burial-transit   | Examiner                      | Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events   | c                                 |                             |  |   |                                   |                                   |   |  |  |  |
| 0,                         | an a  |                               | resulting in death) Last  | Due to (or as                     | a consequence of            | ):   |   |                                   |                                   |   |  |  |  |
| 760,                       |   | cal                           |   | d                                 |                             |  |   |                                   |                                   |   |  |  |  |
| 68                         | eath certificat<br>attending phy<br>I for use as the  | ed                            |   |                                   |                             |  |   |                                   |                                   |   |  |  |  |
| Вох                        | n cer<br>andin<br>use   | 5                             | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome              |                             | - 77   |   | 23d                               | . Date of deliver                 | ry  |  |  |  |
| m                          | death<br>a atte   | cla                           | in the past 12 months?<br>1 ☐ Yes 2 ☑ No  | 1 □ Live birth<br>4 □ Pregnant at | 2 Fetal death time of death | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)                                    |   |                                   |                                   | Day Year                                      |  |  |  |
| P.O.                       | by the a  | Physician/Med                 | 9 Unknown   | 9□ Unknown                        |                             |  |   |                                   |                                   |   |  |  |  |
| σ.                         | The law requires that the death certifica<br>ate has been signed by the attending ph<br>bage 2 should be detached for use as th   |                               | Part II. Other significant conditions   | contributing to death bu          | rt I. 23e. Did              | tobacco use  | bacco use contribute to the cause of death?                                       |                                   |                                   |   |  |  |  |
| qs                         |   | d by                          |   |                                   |                             |  | 1   | Yes 2                             | 3 ☐ Proba                         | Probably 4 Unknown                            |  |  |  |
| Ď                          |   | Completed                     |   |                                   |                             |  |   | •                                 |                                   |   |  |  |  |
| ě                          | e law<br>has l  | npi                           |   |                                   |                             |  | 24a. Wa   | opsy                              | prior to com                      | sy findings available<br>apletion of cause of |  |  |  |
| =                          | The cate has  | ပ္ပြဲ                         |   |                                   |                             |  | per<br>1 ☐ Yes  | formed?<br>2 🖳 Ro                 | death?                            | 2 <b>3 1 1 1</b>                              |  |  |  |
| ita<br>Eta                 | Physician: Th<br>this certificate<br>ral director, pag  | Be                            | 25. Was case referred to medical examiner?  |                                   |                             | 26. Pla  | ace of Death (Check only  | one)                              |                                   |   |  |  |  |
| <b>=</b>                   | physic<br>this co   | 2                             | 1   Yes   2   FNo   Hospital: Phopatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specify)  |                                   |                             |  |   |                                   |                                   |   |  |  |  |
|                            |   | ü                             | 27. Manner of Death 1 Natural 5 ☐ Pending   | 28a. Date of Injur<br>(Month, Day | y 28b. Tir<br>Year) Inji    |  | 28d. Describe   | how injury or                     | curred                            |   |  |  |  |
| . <u>ō</u>                 | 19 F. 82  | afic                          | 2 Accident investigation  |                                   | ,                           | M 1 ☐ Yes 2  | □No   |                                   |                                   |   |  |  |  |
| <u>×is</u>                 | I or Attend<br>after death<br>Director:   | €                             | 3 Suicide 6 Could not be determined   | 286. Place of Inju                | ry - At home, farn          | n, street, factory, office   | 28f. Location   | (Street and N                     | umber or Rural                    | Route Number,                                 |  |  |  |
|                            | al Oir  | Certification:                | 4 - Houncide  | building, etc                     | с. (Эрөспу)                 |  | City or 1   | own, State)                       |                                   |   |  |  |  |
|                            | hour<br>hour<br>nere<br>y fille   |                               | 29a. Certifier 1 Certifying Pl  | nysician: To the best of          | of my knowledge,            | death occurred at the time, date   | and place, and due to the   | e cause(s) and                    | d manner as sta                   | ated.   |  |  |  |
|                            | n 24 l  | dical                         | 29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                   |                             |  |   |                                   |                                   |   |  |  |  |
|                            | To the Hospitel or Atte<br>within 24 hours after de<br>To the Funerel Directo<br>Completely filled in by th   | Me                            |   |                                   |                             |  |   |                                   |                                   |   |  |  |  |
|                            | 0   |                               | Anno  |                                   |                             |  |   | 1                                 | 1001                              | Ø   |  |  |  |
|                            | Mrs.  | 1                             | 30. Name and address of person who  | completed cause of de             | ath (Item 22a) /T           | (De Print)   | 30-110  | - '/                              | 7/0                               | •   |  |  |  |
|                            | G.,   |                               | SO, ITALITY ALIO AMORASS OF PRISON WITO   | completed cause of de             | outri (11811) (1)           | ice 2n   | 58410   | Acres                             | Steel                             |   |  |  |  |
|                            | C4  |                               | 31. Date filed (Month, Day, Year)   | 32. vegistra                      | r's Signature               | 1 100  | + 1153 2  | 77                                | the same                          | T. 09.17. On                                  |  |  |  |
|                            | Sta   |                               | FFR 0.1.2   | 008                               | 16                          | Booch 1  |   |                                   |                                   |   |  |  |  |

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|  |                               | 1 - For<br>State<br>Registrar  | State of Ma   |  | l / Depa   |  | t of H         | lealth a          |  |  | ygiene<br>Reg. No. 2           | 2008                                   | 0449   |
|--|-------------------------------|--|---|--|--|--|----------------|-------------------|--|--|--------------------------------|--|--|
| Physi  |                               | 1. Decedent's Name (First, Middle, Las.  WILLIAM PAUL  | ELLIOTT   |  |  |  |                |                   |  | 2. Date of D<br>Month<br>Januar            | Day                            | , 2008                                 | 3. Time of Death 7:35 AM                           |
| /Med<br>Exam   |                               | 4a. Facility Name (If not institution, give<br>Shady Grove Adver   |   |  |  | 4b. City, Town, or Location of Death Rockville |                |                   |  | 4c. C                                      | 4c. County of Death Montgomery |  |  |
| Funera<br>Directo  |                               | 5. Social Security Number 469-24-1375  Usual Residence of Decedent   | X 7. Age<br>XIM 2□F   | e (In yrs. Ia:   | st birthday)<br>Yrs.   | If Under<br>Months                             | 1 Year<br>Days | If Under<br>Hours | 24 Hrs.<br>Min.                                  | 8. Date of B<br>(Month, I<br>June          | irth 192<br>16,192             | 9. Birth                               | place (State or Foreig<br>intry)<br>Inois          |
| e Maryland<br>Ba-f show<br>tified at   | ctor                          | 10a. State 10b. County MD Montgome   | nery Gaithersburg   |  |  |  |                |                   |  |  |                                | 10d. Inside City Limits 1 ☐ Yes 2 ☒ No |  |
| with this a or 20  | Dire                          | 10e. Street and Number   | e. Street and Number 10f. Zip Code 211 Russell Ave #75 20877                |  |  |  |                |                   |  |  |                                | en of What Cou<br>d State              | •  |
| Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at more in the manual or t | Completed by Funeral Director | 11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced   | Ever in U.S.  | ver in U.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto |  |  |                |                   |  |  |                                |  |  |
| 21215-0036 ed within 72 hours af rgiene. er than "natural", or the Medical Exami   | Completed                     | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-5+  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Research Physisist |  |                |                   |  | rking  U.S. Federal                        |                                |  | ,  |
| Maryland nd 2 should be file lith and Mental Hy 27 is marked oth   | To Be (                       | William Elliott Fred   |   |  |  |  |                | reda              | ame (First, Middle, Maiden Surname)<br>a Umbreit |  |                                |  |  |
| Mai<br>ind 2 sh<br>alth and<br>27 Is m   |                               | 19a. Informant's Name/Relationship (T) Marie G. Elliott  | ·   |  |  |  |                |                   |  |  |                                | own, State, Zi                         |  |
| Baltimore, permit. Pages 1 ar Department of Hee mportant: If item may injury or other more.  |                               | 20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)   | Removal from State  | 1  | ce of Dispo<br>metery, crer  |  |                | e)                | Janos  | 30,  |                                | ation - City or T                      | •  |
| Balt permit. Departi   |                               | 21. Signature of Funeral Service Licens  | by  |  | _   1  |  | t De           | er Pa             | ark I  |  | thers                          |  | D 20877  |
| Physician<br>/Medical<br>Examine   |                               | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)  | ication that caused<br>ne cause on each lin<br>a                            |  |  |  |                |                   |  | or respiratory  119  Clut                  |                                |  | Approximate<br>Interval Between<br>Onset and Death |
| #  | ical Examiner                 | Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | Due to (or as a   | a donisoque  |  | ascq   | Lus            | 1                 | ccà  | dent                                       |                                |  | years  |
| I Records, P.O. Box 68760,  The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit.  | Physician/Med                 | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 3c. If yes, outcome p<br>1 □ Live birth 2<br>4 □ Pregnant at<br>9 □ Unknown | 2 🗆 Fetal d  | leath 3□   | Ectopic pre                                    |                |                   |  |  | 23                             | d. Date of deliv                       | ery<br>Day Year                                    |
| ds, F<br>Lires that<br>signed to<br>d be det   | þ                             | Part II. Other significant conditions co   | htributing to death bu  |  |  | , ,  |                | ***               | ises   |  | tobacco use                    | *                                      | the cause of death?                                |
|  | Completed                     | Hyperten   | Sian  |  |  |  |                |                   |  | 24a. Was                                   |                                | 24b. Were auto                         | opsy findings available<br>impletion of cause of   |
| OF<br>Phys   | n: To Be                      | 27. Manner of Death  | lospital: 1 Inpatier 28a. Date of Injun                                     | у 2  | R/Outpatien<br>8b. Time of<br>Injury   |  | Othe           | r: 4 🗆 Nu         | rsing Hor  | (Check only<br>ne 5 ☐ Res<br>28d. Describe | idence 6 [                     | Other (Speci                           | fy)  |
| Division  To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune   | Certification:                | 1 SNatural   5 Pending   (Month, Day Year)   Injury   Work?     2 Accident   investigation   M   1 Yes 2 No     1 Yes 2 No     28e. Place of injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route of City or Town, State)   28f. Location (Street and Number or Rural Route of City or Town, State) |   |  |  |  |                |                   |  | al Route Number,                           |                                |  |  |
| le Hospital<br>24 hours :<br>re Funeral  | Medical Co                    | 29a. Certifier (Check only one)  Certifying Physical (Check only one)  | sician: To the best of<br>ner: On the basis of<br>and manner stat           | examinatio   | n and/or inv   | estigation,                                    | in my op       | inion, dea        | th occurr  | ed at the time                             | , date and p                   | lace, and due t                        | o the cause(s)                                     |
| To the within 2 To the comple  | Me                            | 29b. Signature and title of certifier  | 7   |  |  | 29c.   | License        | number            |  |  | 29d. Date s                    | signed (Month,                         | Day, Year)   |
| 10   |                               | 30. Name and addless of person who co  | mpleted cause of de   | ath (Item 2  | 3a) (Type, F   | > [  | )0             | 054               | 16.  | 5 3  | Janu                           | 4m 2                                   | Day, Year) 9, 2008 20850                           |
|  | ate                           | 1. Date filed (Month, Day, Year)   | 40 999<br>32 Jegistrai  | o / M  | edica  | L Ce   | ster           | Driv              | Q,   | Rodu                                       | ille                           | , mo                                   | 50820  |
| Regis  |                               | FEB 0 1 200  | 18 Brew   | 1  | Go   | seles  |                |                   |  |  |                                |  |  |

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician DELBERT TAYLOR FOSTER 06:56A M 2008 JANUARY 31 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1⊠M 2□F 93 479-30-2620 April 21 1914 Kansas Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r 28a-f show notified at show Md. Montgomery Gaithersburg 1 XYes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number must be n 20877 311 S. Frederick Avenue United States Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner 1 □ Never Married 2 □ Married White , o. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 ₩ Widowed 4 Divorced Year or Dates: "naturai", Completed 16b. Kind of Business/Industry Medicai 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Extension Agent Agriculture 12 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louisa Adair Grace Walter Foster James 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 Alta Vista Drive, Ringwood, New Jersey 07456 : If item 27 i Richard F. Edwards / Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o important: If any injury or once. Laytonsville, Md. Laytonsville Cem. 2/5/08 4 Donation 5 Dother (Specify) 21. Sign fun of Funeral S. Nio Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home 20882 m-00470 Box 5038, Laytonsville, P. O. 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** My o cardia /Medical Due to (or as a consequence of): Examiner ardio ulmon Sequentially list conditions, if any, leading to lumine flats cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical attending p 23c. If ves. outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 9☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2ÆR/Outpatient 3 DOA 1 Inpatient 2 this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Injury (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by determined 4 Homicide within 24 hours a To the Funeral I 🗽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 65385 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 9501 Medual Cente Alex Rosin

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State

Registrar

31. Date filed (Month, Day, Year)

FEB

04

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month **Physician** 2, 4:05A Katie Mariea Theresa Gilrov February 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🛣 F March 7, 1935 Director 578-44-0694 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 □ Yes 2 N No MD St. Mary's Mechanicsville Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 37970 Stasch Road 20659 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 2**X**) No altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify white Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) 12 Mail Carrier US Postal Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred Brand Gertrude Geiger ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Debra Gilroy/Daughter 39254 Wisteria Ct.Mechanicsville,MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ment of H ant: If ite ury or otl 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once, Brinsfield-Echols Crem. 2/5/08 Charlotte Hall, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of uneral Service Licensee M00945 22 Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. asc. Ehug 211 St. Mary's Ave. La Plata,MD 20646 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Pnenmon /Medical Due to (or as a consequence of) Examiner Cancinoma Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to for as a nonanguenno off Examiner burial-tran Due to (or as a consequence of): Box 68/60. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 No Vital certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 11 Impatient 3□ D0A 2 ER/Outpatient မ this Division or 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation **Natural** 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after Dire 24 hours at 29a, Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D60888 M-D 4. 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rakhi Krishnan, M.D. 24035 Three Notch Road, Hollywood, MD 20636 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State Sparke 2008 FFB 0 4 Registrar

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